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Confidential Medical History Form

Welcome to my practice! In order to provide the best and safest care for you, I would be grateful if you could complete this form. Any information given will **be kept strictly confidential**. Please also inform us if there are any changes to your name, address or telephone number.

Name_____

Date of Birth_____ Title: Mr / Mrs / Miss _____

Address_____

_____

_____ Postcode_____

Telephone_____ Mobile_____

Next of Kin_____ Contact Number_____

Your doctor's name_____

Your doctor's surgery_____

Are You?	**YES**	**NO**
Receiving treatment from any doctor?		
Taking any medicines / tablets from your doctor?		
Taking / have taken any steroids in the last 2 years?		
Allergic to any medicines or materials? Which?		
Likely to be pregnant? Due date:		

Have you?	**YES**	**NO**
High blood pressure?		
A heart problem or had a heart attack? Details or date:		
Had rheumatic fever or a heart murmur?		
Had infective endocarditis or had any heart surgery?		
Had a blood test recently?		
Ever had a stroke?		
Had a bad reaction to local or general anaesthetic?		

Have you?	**YES**	**NO**
Had a major operation or recently been in hospital?		
Ever had blood refused by the Blood Transfusion Service?		
Ever been diagnosed or suspected as having V-CJD or being HIV-positive?		
Ever been diagnosed with any of the following: ADHD, Asperger Syndrome, Autism or Dyspraxia?		

Do You?	**YES**	**NO**
Have a pacemaker?		
Have diabetes?		
Carry a warning card? Re: _____		
Carry any emergency medication e.g. EpiPen?		
Suffer from asthma or bronchitis?		
Bruise easily or have you ever bled excessively?		
Have fainting attacks, giddiness or epilepsy?		
Have a history of mental illness or eating disorders?		
Smoke? If yes, how many a day? ___		
Drink alcohol? If yes, how many units a week? ___		

Are there any other aspects of your health that you feel we should know about?

_____

_____

_____

Please list any medicines you are taking currently:

_____

_____

_____

Thank you for your help and co-operation.

Patient's Signature _____ **Date** _____