Confidential Patient Medical History

Full name: _____

Date of birth: _____ Title: Mr/Mrs/Miss/Ms/Dr/Other

Address: _____

_____ Postcode: _____

Telephone numbers Home: _____ Work: _____ Mobile: _____

Email address: _____

☐ Please tick box if happy to receive emails from us

Have you ever had or do you suffer from:

Any heart complain:
☐ Yes ☐ No

High/low blood pressure:
☐ Yes ☐ No

Epilepsy:
☐ Yes ☐ No

Chest problems:
☐ Yes ☐ No

Jaundice/Hepatitis:
☐ Yes ☐ No

Gastro intestinal condition, i.e Colitis
☐ Yes ☐ No

Rheumatic fever:
☐ Yes ☐ No

HIV/Aids:
☐ Yes ☐ No

Diabetes:
☐ Yes ☐ No

Excessive bleeding/bruising:
☐ Yes ☐ No

Have you taken steroids in the last 2 years?
☐ Yes ☐ No If yes please specify: _____

Had any blood tests within the last 2 years?
☐ Yes ☐ No If yes please specify: _____

Are you allergic to any medication/products (Latex) or foods?
☐ Yes ☐ No If yes please specify: _____

Have you taken any medication recently or are you under a course of treatment at present?
☐ Yes ☐ No If yes please specify: _____

Do you smoke?
☐ Yes ☐ No If yes how much/many? _____

Do you drink alcohol?
☐ Yes ☐ No If yes how many units? _____

Is there anything else not mentioned above that we should know about? _____

_____

We would be grateful if in the future you would keep us informed of any changes to the above.

Signed: _____ Date: _____ Signed: _____ Date: _____

Signed: _____ Date: _____ Signed: _____ Date: _____

Signed: _____ Date: _____ Signed: _____ Date: _____