Medical History Form Date

Name: ....

Address: ..... Post Code:.....

Home Telephone Number ..... Mobile .....

Email: .....

Occupation..... ... Date of Birth.....

How did you hear about us? .....

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning health.

Are you currently receiving treatment from a doctor, hospital or clinic?	No	Yes
2. Are you taking any regular/prescribed medication?	No	Yes
3. Are you pregnant or possibly pregnant?	No	Yes
4. Are you currently carrying a medical warning card?	No	Yes
5. Do you have allergies to any medicines (e.g. antibiotics), substances (e.g. latex/rubber) or foods?	No	Yes
6. Do you have diabetes?	No	Yes
7. Do you suffer from hay fever or eczema?	No	Yes
8. Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	No	Yes

9. Do you have bronchitis, asthma or other chest condition?	No ○	Yes ○
10. Do you suffer form arthritis?	No ○	Yes ○
11. Do you get bruising or persistent bleeding following injury, tooth extraction or surgery?	No ○	Yes ○
12. Do you smoke?	No ○	Yes ○
13. Have you ever had any infectious diseases including HIV or hepatitis?	No ○	Yes ○
14. Have you ever had heart surgery?	No ○	Yes ○
15. Have you ever had heart problems, angina, blood pressure problems, stroke or pacemaker?	No ○	Yes ○
16. Have you ever had a bad reaction to general or local anaesthetic?	No ○	Yes ○
17. Have you ever had rheumatic fever or chorea (St Vitus Dance)?	No ○	Yes ○
18. Have you ever suffered form liver disease (E.g. jaundice, hepatitis) or kidney disease?	No ○	Yes ○
19. Have you ever had any other serious illness or infectious disease?	No ○	Yes ○
20. Have you ever had blood refused by the Blood Transfusion Service?	No ○	Yes ○
21. Have you ever had a joint replacement or other implant?	No ○	Yes ○
22. Have you ever had treatment that required you to be in hospital?	No ○	Yes ○
23. Have you ever had brain surgery?	No ○	Yes ○

Patient signature .....

Date.....