# CONFIDENTIAL MEDICAL HISTORY FORM

To enable us to treat you safely we require to ask you for some information about your general health. Please write your contact details, answer the health questions and sign the form. At later visits we will check the information given to see if there have been any changes in your general health. *All information will be kept strictly confidential.*

| TITLE: NAME: D.O.B.: | | | |
|---|---|---|---|
| ADDRESS: | | | |
| TEL.NO. HOME: WORK; **Email address;** OCCUPATION:<br>Please sign here if you agree to us telephoning and leaving a message at this number……. | | | |
| DOCTOR'S NAME & ADDRESS | | | |
| **ARE YOU:** | **YES** | **NO** | **DETAILS** |
| 1. Pregnant | | | |
| 2. Attending or receiving treatment from a doctor, hospital, clinic or specialist? | | | |
| 3. Taking any medicines from your doctor? | | | |
| 4. Taking or have you taken steroids in the last two years? | | | |
| 5. Allergic to any medicine (eg antibiotics), materials (eg latex/rubber) or foods? | | | |
| **HAVE YOU:** | | | |
| 1. Had rheumatic fever or chorea (St Vitus Dance)? | | | |
| 2. Had jaundice, liver, kidney disease or hepatitis? | | | |
| 3. Had any blood tests? | | | |
| 4. Ever had your blood refused by The Blood Transfusion Service? | | | |
| 5. Ever been told you have a heart murmur or heart problem, angina, blood pressure or heart attack? | | | |
| 6. Ever had a bad reaction to a general or local anaesthetic? | | | |
| 7. Had a joint replacement or other implant? | | | |
| 8. Had growth hormone treatment before the mid 1980's? | | | |
| 9. Been hospitalised? If 'YES' for what and when? | | | |
| **DO YOU:** | | | |
| 1. Have arthritis? | | | |
| 2. Have a pacemaker? | | | |
| 3. Suffer from hay fever, eczema or any other allergy? | | | |
| 4. Suffer from bronchitis, asthma or any other chest condition? | | | |
| 5. Have fainting attacks, giddiness, blackouts or epilepsy? | | | |
| 6. Have diabetes? | | | |
| 7. Bruise easily or persistently bleed following injury, tooth extraction or surgery? | | | |
| 8. Suffer from any infectious diseases (including H.I.V.)? | | | |
| 9. Have a close relative with Creutzfeld Jakob Disease? | | | |
| 10. Carry a warning card? | | | |
| 11. Smoke? If yes, approximately how many each day? | | | |
| 12. Drink alcohol? If yes, approximately how many units each week? | | | |
| **PLEASE NOTE:** | | | |
| We are obliged to inform you that the information we hold about you on our computer system could be used in various ways. These are listed on the information sheet at our reception. You should read this.<br>By signing this form, you agree to your information being used unless you inform us here. | | | |
| **SIGNED BY: SELF/PARENT/GUARDIAN……..DATE……...** | | | |
| **Have there been any changes in your health since your last course of treatment?** | | | |

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|---|---|---|---|
| DETAILS<br>Signature:<br>Date | DETAILS<br>Signature:<br>Date: | DETAILS<br>Signature:<br>Date: | DETAILS<br>Signature:<br>Date: |