CONFIDENTIAL MEDICAL HISTORY

Name: _____ **D. o B.** _____

Address: _____ **Tel No:** _____

_____ **Postcode:** _____

Doctor's Name: _____

Address: _____

To obtain the best and safest care, we need to know any problems, which may affect your treatment.

Please complete this questionnaire (if under 16 by parent or guardian).

HAS THE PATIENT EVER HAD THE FOLLOWING:	Yes	No	Details
1. Rheumatic Fever			
2. Heart trouble or murmur, high blood pressure			
3. Chest trouble, asthma, bronchitis			
4. Jaundice, liver or kidney trouble			
5. Indigestion, heartburn			
6. Diabetes			
7. Fainting attacks, fits or convulsions			
8. Anaemia or blood disorders			
9. Prolonged bleeding from cuts, extractions			
10. HIV or Hepatitis Infection			
11. Previous operations or general anaesthetics (give approx times)			
12. Any problems with anaesthetics (patients or family)			
13. Any other illnesses			
14. Allergies			
15. Are you seeing a doctor or waiting to see a doctor for any reason at present?			
16. Are you taking any: Drugs, pills, medicines/inhalers?			
17. Are you using any skin ointments?			
PLEASE COMPLETE IF APPROPRIATE:			
Recent cough/cold			
Smoker (quantity per day)			
Alcohol (quantity per week)			
Suspected/confirmed pregnancy - FEMALES ONLY			

Signed: _____ Date: _____ / _____ / _____

UPDATE: Have there been any changes in your health or medicines since your last course of treatment?

Date: ____ / ____/ _____ Y/N Signed: _____ Date: ____ / ____/ _____ Y/N Signed _____