MEDICAL HISTORY FORM – CONFIDENTIAL

Name (Mr,Mrs,Miss,Ms): ….....

Address: ……

HomeTel: ……..... Daytime Tel: …… Mobile: ……

Occupation: ……..……. Expectant Mother: Yes / No Breastfeeding: Yes / No

Nationality: ……..…….. Date of Birth: …… Pay for treatment: Yes / No

Please answer Yes or No to the following questions. (Give brief details if you can).

1	Do you have any general health problems?	Yes / No	Details:……
2	Do you have any heart complaints?	Yes / No	……
3	Do you have any lung or breathing problems?	Yes / No	……
4	Have you had a stroke or blood clot in your leg?	Yes / No	……
5	Do you have any stomach or bowel problems?	Yes / No	……
6	Are you allergic to medicines, foods, or materials?	Yes / No	……
7	Do you suffer from epilepsy, black-outs, or faints?	Yes / No	……
8	Are you depressed or overly anxious?	Yes / No	……
9	Do you bleed excessively following a cut or extraction?	Yes / No	……
10	Have you had rheumatic fever?	Yes / No	……
11	Have you had hepatitis or jaundice?	Yes / No	……
12	Are you a diabetic?	Yes / No	……
13	Are you seeing a doctor or specialist?	Yes / No	……
14	Have you ever been hospitalised?	Yes / No	……
15	Have you taken any medications, cream/ ointments recently?	Yes / No	……
16	Would you be rejected as a blood donor?	Yes / No	……
17	Have you had any problems with anaesthesia or sedation?	Yes / No	……
18	*Do you have any of the symptoms of Covid?*	Yes / No	……
19	*Have you had Covid Vaccines? How many times?*	Yes / No	……
20	*Have you had Covid infection previously?*	Yes / No	……

<u>Your Doctor's Name and Address</u>

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……

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Telephone:……

<u>Parent / Guardian / Carer):</u>

……

Signature

Date: ……