CONFIDENTIAL MEDICAL HISTORY FORM

Surname:	First name(s):	
Date of birth:	Title:	M/F
Home address:		
Tel: (home):	Mobile:	
Email:	Occupation (if relevant)	
Doctor's name & address: Tel:		
Contact in case of an emergency: Tel:		

What is your ethnic group?

☐ White British ☐ White Irish ☐ Other White background
☐ White & Black Caribbean ☐ White & Black African ☐Asian or Asian British Pakistani
☐Asian or Asian British Indian ☐ Asian or Asian British Bangladeshi ☐ Other Asian background
☐ Black or Black British African ☐ Black or Black British Caribbean ☐ Other Black background
☐ Other mixed background ☐Chinese ☐ Any other ethnic group
☐ Patient declined

Is your current BMI (Body Mass Index) over 30? Y/N

Are you currently:

Receiving treatment from a doctor, hospital, or clinic? If yes, please give details:	Y/N
Carrying a medical warning card? If yes, please give details:	Y/N
Pregnant? If yes, please give due date: Are you trying to conceive?	Y/N Y/N

Do you experience chest pain upon exertion (angina pectoris)? If so,	Y/N
Have you had to reduce your activities?	Y/N
Do you have chest pain at rest?	Y/N
Have you ever had a heart attack? If so	Y/N
Do you still have complaints?	Y/N
Have you had a heart attack in the last 6 months?	Y/N

Have you ever had high blood pressure?	Y/N
Do you have a tendency to bleed excessively after injury, surgery or tooth extraction? If so,	Y/N
Do you suffer from spontaneous bruising?	Y/N
Do you have epilepsy? If so,	Y/N
Do you continue to have seizures?	Y/N
Do you suffer from asthma? If so,	Y/N
Do you use inhalers?	Y/N
Is your breathing difficult today?	Y/N
Do you have hayfever or eczema?	Y/N
Do you have other lung problems? If so,	Y/N
Are you short of breath after climbing stairs?	Y/N

Do you have a heart murmur, heart valve dysfunction or an artificial heart valve?	Y/N
Have you had heart or vascular surgery in the last 6 months?	Y/N
Have you ever had rheumatic fever?	Y/N
Have you had endocarditis?	Y/N
Do you have heart palpitations without exertion? If so,	Y/N
Do you have to rest, sit down, or lie down during palpitations?	Y/N
Are you short of breath, pale or dizzy at these times?	Y/N
Do you have problems lying flat? If so,	Y/N
Do you need more than 2 pillows at night due to shortness of breath?	Y/N
Do you suffer with thyroid disease? If so	Y/N
Is your thyroid gland overactive?	Y/N
Do you suffer from liver disease (i.e. jaundice, hepatitis)? If so,	Y/N
Have you had a liver transplant?	Y/N
Do you have a kidney disease? If so,	Y/N
Are you undergoing haemodialysis?	Y/N
Have you had a kidney transplant?	Y/N
Have you ever had an operation? If so,	Y/N
Have you had GA or sedation?	Y/N
Were there any complications?	Y/N
Have you ever had a joint replacement?	Y/N
Have you ever had a reaction to a GA or LA?	Y/N
Have you ever had a malignant disease or leukaemia? If so,	Y/N

Are you short of breath getting dressed?	Y/N
Do you have any allergies to any medicines (e.g. antibiotics), substances (e.g. latex/rubber) or foods?	Y/N
Does anyone in your family?	Y/N
Do you have diabetes? If so,	Y/N
Are you on insulin?	Y/N
Is your diabetes poorly controlled at present?	Y/N
Do you suffer from arthritis? If so,	Y/N
Rheumatoid arthritis?	Y/N
Osteoarthritis?	Y/N
Have you ever had a stroke?	Y/N
Do you suffer from coldsores?	Y/N
Have you ever fainted?	Y/N
If so, when?	
Do you have any neurological disorders?	Y/N
Multiple Sclerosis	Y/N
Parkinson's disease	Y/N
Huntington's Chorea	Y/N
Other (specify):	Y/N
Do you drink alcohol? If so,	Y/N
How many units per week? *(a unit is half pint lager, single measure, or single glass wine/aperitif)*	
Do you smoke?	Y/N
What do you smoke?	
How many per day?	
Have you ever smoked?	Y/N
Do you chew tobacco products?	Y/N
Pan	Y/N
Supari	Y/N
How many times per day?	Y/N
Have you chewed them in the past?	Y/N

Have you ever had chemotherapy or a bone marrow transplant?	Y/N	
Have you ever had radiotherapy for a tumour or growth in the head or neck?	Y/N	
Have you suffered from/are suffering from an infectious disease? (e.g. HIV or hepatitis). If so, please give details:	Y/N	

Do you take any of the following medication?

☐	For a heart complaint.	☐	Hormone replacement therapy.	☐	For diabetes?	☐	Aspirin or other painkillers.
☐	For high blood pressure.	☐	Drugs against transplant rejection.	☐	For sleeping disorder, depressive conditions or anxiety states.	☐	Corticosteroids (systemic or topical).
☐	For an allergy.	☐	For skin, bowel, or rheumatic diseases.	☐	Contraceptive pill.	☐	Other medication? If so, please specify.

Is there anything else we should know about your general health?

Please list your medication here:

Name	Dose	How long have you taken this medication?

Please check that the health information on this form is still correct (including information on smoking and drinking).

If there is no change, please initial below.

If there have been any changes to your medical history, please amend the form.
Please also list these changes below and then sign where indicated.

Date	No Change	List any changes below	Patient's signature