

CONFIDENTIAL MEDICAL AND FAMILY HISTORY FORM

Name
Address
..... Post Code
E-mail Mobile
Tel No: Home Work
Date of Birth Occupation
Doctor

FAMILY HISTORY - Please give details of your family's health. Include major illnesses and long-term conditions and anything unusual.

Mother.....
Father.....
Mother's mother.....
Mother's father
Father's mother.....
Father's father.....
Brothers & Sisters
Other relatives.....

CHILDHOOD DISEASES - please tick if you have suffered from:

Chicken pox , German measles , Measles , Mumps ,
Whooping cough , Scarlet fever , Diptheria , Any other

Immunisations Any adverse reactions

OPERATIONS - details and approx age.....

Drugs

Food Supplements, Vitamins Herbal remedies, etc.

MEDICAL HISTORY – Please tick if you have ever suffered any of the following:-

Abscesses/Boils , Allergies , Anxiety , Asthma , Blood pressure , Dental ,
Digestion , Dizziness , Epilepsy , Fears/Phobias , Glandular fever ,
Gynaecological , Hay fever , Heart , Headaches/Migraine , Hepatitis ,
Insomnia , Joints , Kidneys/Urinary , Menstrual , Piles , Pregnancy ,
Problems at your birth , Sexually transmitted diseases , Sinusitis , Skin problems ,
Thyroid , Varicose veins , Warts/moles .

Any other, please name
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