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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