Medical History Form

Name ----------------------------------------------------------- DOB --------------------------

Name & Address of your Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever suffered from any of the following? | YES | NO |
| |  | | --- | | Heart/Circulatory Illness/Hypertension | |  |  |
| |  | | --- | | Diabetes | |  |  |
| |  | | --- | | Asthma/Hay fever | |  |  |
| |  | | --- | | Bronchitis/Pneumonia/Pleurisy | |  |  |
| |  | | --- | | Epilepsy | |  |  |
| |  | | --- | | Headaches/Migraine | |  |  |
| |  | | --- | | Tuberculosis | |  |  |
| |  | | --- | | Psychiatric Illness/Anxiety/Depression | |  |  |
| |  | | --- | | Dermatitis/Psoriasis/Eczema | |  |  |
| |  | | --- | | Back problems | |  |  |
| |  | | --- | | Recurrent infections | |  |  |
| |  | | --- | | Hepatitis/Jaundice | |  |  |
| |  | | --- | | Are you taking any prescription drugs? | |  |  |

If you have answered yes to any of the above questions please give details --------------------------------------

Are you vaccinated against Hepatitis B? Yes/No If Yes, Please provide the dates.

If you are not vaccinated we strongly recommended that you are. Please arrange this with your GP.

Any other medical condition or disability? Yes/No If Yes, Please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I declare that the answers given are true and correct and give a full and complete picture of my health in every respect.

Signature -------------------------------------------------------- Date ---------------------------------