Duddingston Park

MEDICAL HISTORY FORM

Title:	Forename:	Surname:
D.O.B:	Address:	
Postcode:	Home Tel:	Mobile:
Email:	Occupation:	
GP Name & Address:		

ARE YOU?	YES	NO	DETAILS
Attending/receiving treatment from a doctor/hospital or clinic?			
Taking any medicines, tablets or pills?			
Allergic to drugs, substances or latex?			
Likely to be pregnant or breastfeeding?			
Suffering from an infectious disease e.g H.I.V, Hepatitis?			
Carrying a medical warning card?			
Suffering from Diabetes, liver or kidney disease, any other serious illness?			
Suffering from Arthritis, do you bleed or bruise easily?			
Hay fever or eczema sufferer?			

HAVE YOU HAD?	YES	NO	DETAILS
Heart, stroke or blood pressure problems?			
Heart surgery, valve replacement, joint replacement or implant/pacemaker?			
Rheumatic fever or cholera?			
Chest problems, e.g Asthma, Bronchitis?			
Reaction to local or general anesthetic?			
Hospital treatment or surgery?			
Fainting attacks, blackouts or epilepsy?			
Blood refused by the Blood Transfusion Service?			

DO YOU?	YES	NO	DETAILS
Smoke? If yes, how many per day?			
Drink alcohol? If yes, how many units per week?			
Have a dental phobia?			

We may occasionally wish to contact you with our special offers (letter/sms/email) . You can withdraw your consent at any time by informing us.

☐ I do agree to be occasionally contacted. ☐ I do not agree to be occasionally contacted.

Signature _____ Date _____