PAST HISTORY (YOUR OWN PREVIOUS MEDICAL PROBLEMS)

Heart attack	*(pl.tick)*		*(pl.tick)*
Angina		Asthma	
High Blood Pressure		Cancers	
Diabetes (sugar)		Epilepsy(fits)	
Stroke(s)		Physical disability	
Long term sickness any reason		Mental Health Problems	
		Depression	

Any other medical condition

Do you consent to your medical records being shared by other Health Care Professionals and Agencies (tick box)

Y [ ] N [ ]

Operations performed and year performed in *(eg: hysterectomy)*

	Year

Children Only - Current Vaccination Status

	Date Last Given		Date Last Given
MMR		Tetanus	
Diptheria		Polio	
Pertussis			
HIB			

MEDICATION(S)

Name(s)of any tablets that you take regularly or occasionally such as contraceptive pills or other medication,their strength & daily amount	
1	
2	6
3	7
4	8
5	9
	10

SMOKING STATUS

Please tick

Smoker	
Non-Smoker	
Ex-Smoker	

ALCOHOL INTAKE

Units per week [ ]

Have you ever taken or are you taking recreational drugs?

Yes	
No	