MEDICAL HISTORY FORM – CONFIDENTIAL

Name (Mr,Mrs,Miss,Ms): ……………………………………………………………………………………………

Address: ……………………………………………………………………………………………

HomeTel: …………………….......	Daytime Tel: ………………………	Mobile: ……………………
Occupation: ………………………	Expectant Mother: Yes / No	Breastfeeding: Yes / No
Nationality: ………………………..	Date of Birth: ………………………	Pay for treatment: Yes / No

Please answer Yes or No to the following questions. (Give brief details if you can).

1	Do you have any general health problems?	Yes / No	Details:……………………………………
2	Do you have any heart complaints?	Yes / No	……………………………………………
3	Do you have any lung or breathing problems?	Yes / No	……………………………………………
4	Have you had a stroke or blood clot in your leg?	Yes / No	……………………………………………
5	Do you have any stomach or bowel problems?	Yes / No	……………………………………………
6	Are you allergic to medicines, foods, or materials?	Yes / No	……………………………………………
7	Do you suffer from epilepsy, black-outs, or faints?	Yes / No	……………………………………………
8	Are you depressed or overly anxious?	Yes / No	……………………………………………
9	Do you bleed excessively following a cut or extraction?	Yes / No	……………………………………………
10	Have you had rheumatic fever?	Yes / No	……………………………………………
11	Have you had hepatitis or jaundice?	Yes / No	……………………………………………
12	Are you a diabetic?	Yes / No	……………………………………………
13	Are you seeing a doctor or specialist?	Yes / No	……………………………………………
14	Have you ever been hospitalised?	Yes / No	……………………………………………
15	Have you taken any medications, cream/ ointments recently?	Yes / No	……………………………………………
16	Would you be rejected as a blood donor?	Yes / No	……………………………………………
17	Have you had any problems with anaesthesia or sedation?	Yes / No	……………………………………………
18	*Do you have high temperature or fever?*	Yes / No	……………………………………………
19	*Do you have a new persistent cough?*	Yes / No	……………………………………………
20	*Do you notice any changes in smell or taste?*	Yes / No	……………………………………………
21	*Is any one in your household with the above symptoms?*	Yes / No	……………………………………………
22	*Have you been tested for Covid-19? And the result?*	Yes / No	……………………………………………

Your Doctor's Name and Address

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

Telephone:…………………………………………………………

Signature (Self / Parent / Guardian / Carer):

……………………………………………

Date: ……………………………………