



PERSONAL AND MEDICAL INFORMATION

This information will be kept strictly confidential and will only be accessed in the event of an emergency.

Please complete all fields.

PERSONAL DETAILS

FULL NAME: _____

NEXT OF KIN: _____

DATE OF BIRTH: _____ AGE: _____

RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ MOBILE: _____

ALTERNATIVE EMERGENCY CONTACT

HOME PHONE: _____ MOBILE: _____

NAME: _____

FAMILY DOCTOR: _____

RELATIONSHIP: _____

SURGERY/ADDRESS: _____

HOME PHONE: _____ MOBILE: _____

PHONE NUMBER: _____

MEDICAL INFORMATION

BLOOD GROUP (if known): _____

DATE OF LAST TETANUS VACCINATION: _____

Are you currently being treated for a health problem, either recent or long standing? YES / NO

If YES, please provide details: _____

Are you currently taking any regular medication? YES / NO

If YES, please list _____

Do you have any allergies to, or ever experienced an adverse effect from a medication? YES / NO

If yes, name the medication, and describe the effect it had on you _____

Do you suffer from any other allergy? YES / NO

If YES, provide details _____

Have you ever been hospitalised? YES / NO

If YES, when, and for what reason (including operations)? _____

Have you ever had any serious injuries that required medical attention? YES / NO

If YES, when, and give details _____

Are you a smoker? YES / NO

Have you ever been a smoker? YES / NO

If you do smoke, how many cigarettes per day? _____

How much alcohol do you normally consume in a week? _____

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

Asthma	YES / NO	Shortness of breath	YES / NO
Diabetes	YES / NO	Lung disease	YES / NO
Stroke	YES / NO	Kidney disease	YES / NO
Heart attack	YES / NO	Cancer	YES / NO
Angina	YES / NO	Arthritis	YES / NO
Rheumatic fever	YES / NO	Stomach ulcers	YES / NO
Irregular heartbeat	YES / NO	Epilepsy	YES / NO
HIV/AIDS	YES / NO	Hepatitis	YES / NO
High blood pressure	YES / NO	Thyroid disease	YES / NO

If you answered YES to any of the above, please give details_____

Do you have a family history of any of the conditions listed above? YES /NO

If YES, please give details_____

If there is any further health information you believe may be relevant, please give details here_____
