2023/24 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: ____

DATE OF BIRTH: _______________________ AGE: _____________

ADDRESS: ____

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HOME PHONE: _________________MOBILE: ________________

FAMILY DOCTOR: _______________________________________

SURGERY/ADDRESS: _____________________________________

PHONE NUMBER: _______________________________________

NEXT OF KIN: ____

RELATIONSHIP: _____________________________________

HOME PHONE: ______________ MOBILE: _______________

ALTERNATIVE EMERGENCY CONTACT

NAME: ____

RELATIONSHIP: _____________________________________

HOME PHONE: ______________ MOBILE: _______________

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: ____

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Are you currently taking any regular medication?   YES / NO

If YES, please list ____

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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 ____

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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)? ____

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

If YES, when, and give details ____

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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____

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

If YES, please give details____

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

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