



2019 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 _____
