2025 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: ____

____

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: ____

____

____

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____________________

____

____

____