Medical History Questionnaire

Personal Details

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Email: _____

Gender: Female Male Prefer Not To Say (please circle) Date Of Birth: _____

First Emergency Contact

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Email: _____

Relationship: _____

Second Emergency Contact

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Email: _____

Relationship: _____

Health Care Details

Doctor's Name: _____ Tel: _____

Dentist's Name: _____ Tel: _____

NHS Number: _____

Medical History

Please list any medical conditions that you have (for example asthma, diabetes, epilepsy):

_____

_____

_____

_____

_____

Please list any regular medications you require (include dosage):

_____

_____

_____

Sign: _____ Date: _____