myFACE training

Confidential medical history form

This questionnaire will form part of your confidential clinical records

Title.............................. Surname... Forenames..

Address... Date of Birth ..../........../..........

.... Tel: Home...

.... Work...

Post Code.. Mobile...

Email.. Occupation..

Medical Doctor's name and address..

....

If female:

Please tick if you are:

An expectant or nursing mother

Taking the contraceptive pill

Taking HRT

Please tick if you:

Are receiving medical treatment at present

Are taking any medicines, tablets or injections. If yes please list overleaf

Are you using any complementary therapies or supplements such as St Johns Wort or Vitamin E. If yes please list overleaf

Have taken steroids within the past two years

Have a medical warning card

Please tick if you have or have had:

Endocarditis, heart valve surgery or pulmonary shunt surgery

Rheumatic fever, chorea, heart defects, heart murmur or valve disease

Angina, heart attack or stroke

A pacemaker or heart surgery

Raised blood pressure

Any chest trouble, asthma or TB

Diabetes or epilepsy (or any member of your family)

Fainting attacks

Hepatitis, jaundice, liver or kidney disease

An allergic reaction to Penicillin, latex or other substances

An allergic reaction to local anaesthetic or general anaesthetic

Any operation or illness treated in hospital

Any neurological conditions such as Bell's Palsy, Myasthenia Gravis, Eaton-Lambert

Syndrome, Motor Neuron Disease or Multiple Sclerosis

SAMPLE

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Please tick if:

Your blood has ever been refused by the blood transfusion service
You have ever had contact with or been tested for HIV or AIDS
You have had prolonged bleeding following extraction or surgery
You suffer from a bleeding disorder
You bruise easily
You have been diagnosed with CJD (or any member of your family)
You received growth hormone treatment before the mid 1980's
You currently smoke tobacco products
You have smoked tobacco products in the past
You drink more than 14 units of alcohol per week

Please tick if you have or have had:

Eczema or other skin conditions
Any skin problems such as herpes, infections or cold sores
Keloid or hypertrophic scarring

Please tick if you have taken any of the following within the last 3 days?

Aminoglycoside antibiotics (Gentamicin, Neomycin, Netilimicin or Tobramycin)

Spectinomycin

Penicillamine (antl-rheumatic)

Quinine (anti-malarial)

Calcium Channel blockers (Diltazem, Nifedipine or Verapamil)

Non-depolarising muscle relaxants?

Please make any additional notes here:…………………………………………………………………………

Patient Name: **Patient Signature:**

Date:

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