YOUR MEDICAL HISTORY

Have you ever suffered from :- **(Please circle all that apply)**

Hypertension? High blood pressure? High cholesterol? Angina (chest pain)?

Heart attack? Diabetes? Ever had a stroke? Is your cholesterol high now?

FAMILY HISTORY

Has anyone in your family suffered from any of the following diseases. Please specify relationship i.e. Mother/Father by adding M and/or F

	Under 60	Over 60		Under 60	Over 60
Stroke			Diabetes		
Epilepsy			Asthma		
Heart disease			Thyroid problems		
High Blood Pressure			High Cholesterol		

Your Height	Your Weight	Your Blood pressure	Your BMI

Are you a Carer: Yes/No Do you have a Carer: Yes/No

CURRENT MEDICATION

Please list any **medicines,** which you are currently taking – including any herbal remedies:

Name of tablet/medicine/inhaler	Dose or strength	How many times a day

ALLERGIES

Please list any known allergies:

.....

TETANUS

Approximate date of last Tetanus Vaccination (if known).....

PNEUMOCOCCAL VACCINATION

Approximate date of last Pneumococcal Vaccination (if known).....

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST WITH YOUR REGISTRATION DOCUMENTS. THIS IS ALL REQUIRED FOR ACCEPTANCE ONTO THE GP LIST. THANK YOU.