Medical Assessment Questionnaire

Surname (Mr/Mrs/Miss/Ms) ……………………………………………………...

Forename ………………………………………………………………………

Date of Birth …………………………..

Certain medical conditions can affect your treatment and visa versa

Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Do you have or have you ever suffered from:	Yes	No
Rheumatic fever? ………………………………………………………..	☐	☐
Any heart complaints (including heart murmurs) ………………….	☐	☐
Diabetes?……………………………………………………………….	☐	☐
Epilepsy/Fits/Fainting? ……………………………………………….	☐	☐
Hepatitis? ……………………………………………………………...	☐	☐
Excessive bleeding or taking Warfrin/asprin? ……………………..	☐	☐
High blood pressure/Stroke?………………………………………...	☐	☐
Any other serious illness? …………………………………………...	☐	☐
Are you allergic to any medicine or tablets? (list overleaf) ……….	☐	☐
at present taking any medicine or tablets? (list overleaf) …….	☐	☐
Pregnant? ……………………………………………………...	☐	☐
In the past 2 years have you undergone any operations? (list overleaf)	☐	☐
Been treated with hydro-cortisone or corticosteroids? ……….	☐	☐
Have you ever had joint replacement operations? ……………….	☐	☐
Did you receive growth hormone treatment before the mid 1980's?	☐	☐
Please tick/or tell your practitioner if you are HIV/Hepatitis B Positive	☐	☐

What is your average weekly consumption of alcohol? …………..

If you smoke what is your average per week? ……………………

If "YES" to any of the above questions please supply details in "notes" on the back of the form

© B-Pro-Active Healthcare - Version 2

Please use this space to record any other information that you feel your practitioner should know about your health:

Notes:

Operations:	
Date:	Procedure
Illness:	
Date:	Details
Other:	

Name and address of your doctor:

Name: ………………………………………………………………………..

Address: ……………………………………………………………………..

…………………………………………………………………………………...

Postcode: ………………………

Tel No.: …………………………

If your unsure about any the questions, or if your medical circumstances change, please discuss with your practitioner.

Patient signature:………………………………….. Date: ……………….

© B-Pro-Active Healthcare