Park Private Clinic Confidential Medical History and Health Questionnaire

First Name	Surname
Date of Birth	Contact number
Sex Male / Female / Prefer not to disclose	Todays Date
Emergency contact details	
Name	
Contact Number	
Relationship	
NHS GP Details	
Name	
Address	
Phone number	

Medical History

Current prescribed medication (including inhalers) or 'over the counter' medication	
Past or present medical conditions/problems	
Known allergies	
Do you smoke Y / N	If yes how many oz of tobacco per day? _____ If yes how many cigarettes per day? _____
Do you drink Alcohol Y / N	If yes, how many units per week? (One unit = half pint, small glass wine, one shot)

Disclaimer - ALL PATIENTS MUST COMPLETE THIS SECTION

I confirm that the medical history contained in this document is full, accurate and complete.

I understand that withholding any medical information will be seriously detrimental to my health and safety during any treatment and/or procedure which Park Private Clinic agree to undertake

I confirm that I wish to proceed with my treatment/procedure subject to the Doctors consultation and medical clearance.

Signature Date

Parent/Guardian Date