Claypath & University
Medical Group

Confidential Medical History Questionnaire

Adult or Child Over 14 Years

The contents of this questionnaire are confidential and will be used as part of your medical record. Please use *BLOCK CAPITALS* to make the form easier for us to read.

Personal Details

Surname	
First Name (s)	
Assigned Gender What was your gender assigned at birth	Male / Female
Title e.g. Mr, Mrs	
Date of Birth	
Home Address	
Email Address Please write in capitals	
Mobile Phone	
Home Phone	
Ethnic Origin (optional)	
First Spoken Language	
Place and Country of Birth	

Next of Kin

We will only use this information in an emergency and will not disclose information to them

Name	
Relationship to you	
Telephone	
Address If different to your own	

Personal History

Significant Medical Conditions This includes long term conditions, serious illnesses you have had or major operations. Please continue onto a blank sheet of paper if needed Please include conditions such as: Asthma, Epilepsy, High blood pressure, Diabetes, Thyroid problems, Cancer	
Allergies	
Current Medication Please list all regular medication you take. Please continue onto a blank sheet of paper if needed	
Height Ideally in cm	Weight Ideally in kg
Have you ever served in the British military?	◻ Yes ◻ No
Smoking Status (optional)	◻ Current Smoker. Number per day:__________ ◻ Ex-Smoker ◻ Never Smoked
Alcohol (optional) 1 standard drink is 1 unit. Examples include: 25ml measure of spirit, ½ pint beer/lager, small glass of wine	How often do you have an alcoholic drink? ◻ Never ◻ Monthly or less ◻ 2-4 times a month ◻ 2-3 times per week ◻ 4+ times per week
	How many standard alcoholic drinks do you have on a typical day when you are drinking? ◻ 1-2 drinks ◻ 3-4 drinks ◻ 5-6 drinks ◻ 7-8 drinks ◻ 10+ drinks
	How often do you have 6 or more standard drinks on one occasion? ◻ Never ◻ Less than monthly ◻ Monthly ◻ Weekly ◻ Daily or almost daily
Family history Please list any significant illnesses that have occurred in close family members and which relative had them (parents/brothers/sisters)	

Vaccination History

Please complete the boxes below with the dates of the vaccinations that you have had. If you have not received the vaccination, please write "NA". If you are not sure, please write "Not Sure".

MMR		Polio	
Tetanus		Meningitis C	
ACWY Meningitis		HPV	