Medical History Form

Howe of Fife Medical Practice
The Davidson Building
27 Commercial Road Ladybank
KY15 7JS

We ask you for information about your general health to help us treat you safely. Please complete your contact details below and answer ALL the health questions.
All information will be kept strictly confidential by our staff.

Title:	Surname:	Forename(s):
	Date of Birth: ____/____/_____	Sex: Male ☐ Female ☐
Address:		Postcode:
		Occupation:
Landline:	Mobile:	
Email:		
Marital Status:	Maiden Name:	
Country of Birth:	Ethnic Origin:	
Nationality:		

Are you a Military Veteran? Yes ☐ No ☐ Army ☐ RAF ☐ Navy ☐ Marine ☐

Do you have an F.Med 113? Yes ☐ No ☐

Have you previously been registered with this practice? Yes ☐ No ☐

Do you suffer from any of the following illnesses?

Diabetes Type I ☐ Diabetes Type II ☐ Angina/Heart Disease ☐
Asthma ☐ COPD ☐ Thyroid Disorders ☐
Mental Health ☐ Epilepsy ☐ Stroke/TIA ☐
Hypertension (high blood pressure) ☐ CKD (chronic kidney disease) ☐

Cancer(s) ☐ Type(s) _____

Are you currently receiving any treatment? Yes ☐ No ☐

Other: (Please specify below) ☐

Family History: Do any illnesses run in your family? If yes, please give details below: -

Allergies:

Repeat Medication: (Please list all prescribed medication or attach your repeat slip from your previous practice)

Social History:
Are you a - Smoker ☐ Ex-Smoker ☐ Non-Smoker ☐ E-Cig ☐ Pipe ☐
Daily Average: _____
How any units of alcohol do you drink per week? _____
Do you exercise regularly? Yes ☐ No ☐
Do you or have you abused drugs? Yes ☐ No ☐

Have you been immunised for?
Tetanus: Yes ☐ No ☐ Polio: Yes ☐ No ☐
Pneumococcal: Yes ☐ No ☐
Flu: Yes ☐ No ☐ When was your last flu vaccination? _____

Are you an unpaid carer, or do you have an unpaid carer e.g. family member or friend who cares for you? Yes ☐ No ☐
If so, please enquire at Reception for Carers information.

If you are aged 40 or over - Have you had your blood pressure checked in the past year?
If not, please arrange an appointment with our Practice Nurse.

Do you belong to a Health Insurance Scheme (e.g. BUPA) for private treatment? Yes ☐ No ☐

Females Only:
Have you had a cervical smear? Yes ☐ No ☐ Date of last smear _____
Are you taking oral contraceptives? Yes ☐ No ☐
Do you have a coil (IUCD) or Implant fitted? Yes ☐ No ☐

Emergency Contact

Name: | Telephone Number:

Relationship to you:

In accordance with NHS regulations you are invited, if aged over 5 years, to attend for interview and examination within 28 days. Please arrange an appointment with our Practice Nurse, remember to bring a small urine sample.

SIGNATURE _____ **DATE** _____