**Park Private Clinic**

Confidential Medical History and Health Questionnaire

*Please write clearly in block capitals*

|  |  |
| --- | --- |
| Name: | Sex: Male / Female |
| Occupation: | Marital status: |
| Emergency contact details  Name:  Contact No:  Relationship: | NHS GP details  Name:  Address:  Contact No: |

**Medical History:**

Current prescribed medication (including inhalers):

Current “over the counter” medication:

Known allergies:

Do you smoke? No Yes If **yes**, how many ounces of tobacco per day?

If **yes**, how many cigarettes per day?

Do you drink alcohol? No Yes If **yes**, how many units per week?

(One unit = half a pint, one small glass of wine or 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 agreed to undertake.

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

Signed by patient: Date:

Signed by advisor: Date: