Medical History - Self Report

Last name…… First names……..

Date of Birth…… Married/Single…….

Male/Female…….. Nationality……

Home address……..

……..

Person to contact in the event of an emergency……

Phone number (Home)…… Business……..

PREVIOUS MEDICAL TREATMENT

Please fill in any history you may have of the following: -
YOU MUST ANSWER YES OR NO

	YES/ NO	CONDITION	YEAR
Surgical operation			
In-patient hospital treatment or Any medical condition			
Other important medical treatment			
Psychiatric treatment of any kind			
An allergic reaction to any drug (State which)			
Do you have any long term disability or Chronic illness? (Please give details)			
Are you receiving treatment at present for any condition?			

Any other information we should know……

……..

Foreign countries visited or lived in during the past year……

……..

Have you got medical insurance YES/ NO

Have you got insurance to cover personal effects YES/ NO

N.B. This form is only given to the doctor (if requested) in case of emergency

S:Misc Medical