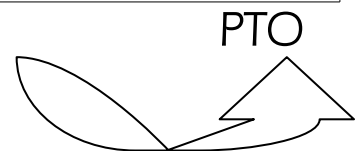


## The Harley Street General Practice Personal Medical History Form

To help us comply with the National Health Care Commission Standards, could you please complete **both sides** of this form as fully as possible.

Title:		Sex:	Male / Female
Surname:		Marital Status:	
Forenames:		Country of Birth:	
DOB:	Age.....	Occupation:	
Address: (For all Correspondence)		Address 2:	
Postcode:		Postcode:	
Home Tel:		Home Fax:	
Work Tel:		Work Fax:	
Mobile No:			
Email:			
Do you have an NHS GP?	Yes / No	Next of Kin:	
NHS GP:		Relationship:	
Address:		Address:	
Postcode:		Postcode	
Tel No:		Tel No:	



Name: .....D.O.B:.....

**Please list important past illnesses, operations and accidents:**

(If possible please state year, place, hospital & specialist):


**Medications (including vitamins, minerals & supplements):**


**Allergies (drug / non-drug / food):**


Do you smoke? Yes / No      If yes, how many per day?      \_\_\_\_\_

Have you had a tetanus vaccination in the last 10 years?      Yes / No

If yes, what was the approximate date you had the vaccination?      \_\_\_\_/\_\_\_\_/\_\_\_\_

Approximate date of last cervical smear (women)      \_\_\_\_/\_\_\_\_/\_\_\_\_

Result of Smear:      Normal / Abnormal / Unsure / Other:      \_\_\_\_\_

Date of any previous Health Assessments      \_\_\_\_/\_\_\_\_/\_\_\_\_

**Do you have any other comments?**


I consent to communication with my NHS GP where appropriate      YES / NO

I would like a chaperone to be present during physical examinations      YES / NO

I would like to be recalled/reminded for any follow-up tests or procedures      YES / NO

I have read a copy of The Harley Street General Practice – Patient Guide      YES / NO

Signed: \_\_\_\_\_      Date: \_\_\_\_\_

*\*\*Thank you for your time\*\**