springs medical
we're here for you

Personal Medical Information

Please hand this form to the doctor or primary care nurse during your consultation

Name ____________________ Date of Birth ____________________

Illnesses and approximate year: Please include all past significant medical problems.

Operations and approximate year: Please include all surgery.

Current Medications (tablets etc.): Include over the counter medications and any vitamins etc.

Allergies:

Family History: Please include all known significant problems in your family

Father

Mother

Siblings

Grandparents

History

Last Tetanus Injection — Date (If Known)

Do you smoke ☐ Yes ☐ No — Average quantity per week

Do you drink alcohol ☐ Yes ☐ No — Average quantity per week

Women Only

Have you had a pap smear ☐ Yes ☐ No — Date of last smear test (If Known)

Space supplied on reverse for extra information if required

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Personal Medical Information

Please hand this form to the doctor or practice nurse during your consultation

Please use this space to add any extra information you require

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