

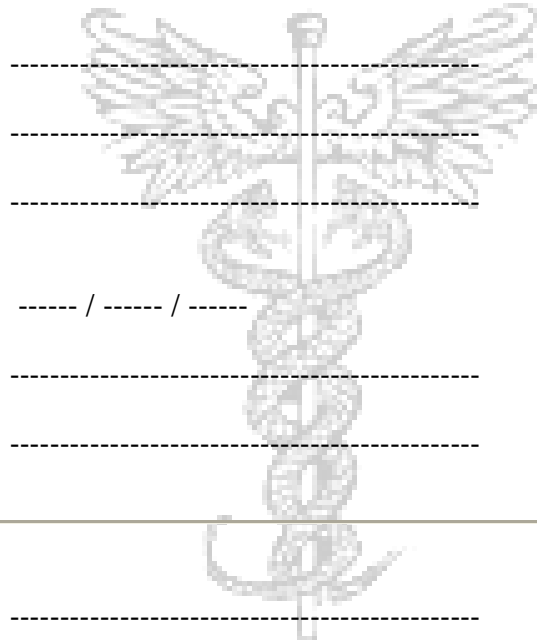
Kiely Healthcare
Confidential Medical Questionnaire Form

To The Patient:
Please complete all sections of this form. ALL information is treated in the STRICTEST CONFIDENCE.

Personal Details

Name: -----

Address: -----



Telephone No: -----

Date of Birth: ----- / ----- / -----

Marital Status: -----

Occupation: -----

Medical Details

Doctor's Name: -----

Doctor's Address: -----

How long have you been registered with the above? -----

Date of last visit: -----

Reason for last visit: -----

Medication

Are you taking any of the following medications? (please circle Yes or No in each case)

Aisprin	Yes	No	Anticoagulants	Yes	No
Heart medication	Yes	No	Epilepsy medication	Yes	No
Antidepressants	Yes	No			

Are you currently taking any other medications?

Name	Dosage	For how long?
-----	-----	-----
-----	-----	-----
-----	-----	-----

Allergies

Are you allergic to any of the following? (please circle Yes or No in each case)

Local Anaesthetic (e.g. during dental treatment)	Yes	No	General Anaesthetic (e.g for appendix operation)	Yes	No
Penicillin	Yes	No	Dressings or Plasters	Yes	No

Any allergies not listed above? -----

List any side effects caused? -----

Medical History

Are you currently suffering from an illness? (please circle Yes or No in each case)

Yes No If 'Yes' please give details: -----

Have you suffered from any illness(es) in the past? Yes No

If 'Yes' please provide details below:

Illness	Date	Result / Outcome
-----	-----	-----
-----	-----	-----
-----	-----	-----

If you have ever had surgery or an accident in the past please give details below:

Type	Date	Result / Outcome
-----	-----	-----
-----	-----	-----
-----	-----	-----

Do you suffer from:

High Blood Pressure Yes No Heart Murmur Yes No

Heart Problems Yes No Heart Attack Yes No

Epilepsy Fits Yes No Depression Yes No

Bleeding Disorder (e.g. haemophilia) Yes No

Other Illnesses Yes No

Have you ever had anaesthetic? **Local** Yes No **General** Yes No

If 'Yes' did you suffer any reaction? -----

Have you ever been tested for?

HIV Yes No Date: ----- Result: -----

Hepatitis (Yellow Jaundice) Yes No Date: ----- Result: -----

Social History

Cigarettes smoked per day: -----

Alcohol units per week: -----

(1 unit of alcohol = ½ pint of beer or small glass of wine)

Family History Of Illness

Has any member of your family ever suffered from illness?

Parents..... Brothers..... Sisters..... Children.....

Other relatives.....

If 'yes' then what illness.....When.....

Investigations:

Have you ever had?

Blood tests..... Date..... Result.....
 Chest X ray..... Date..... Result.....
 ECG (electrocardiogram)..... Date..... Result.....
 Others investigations.....

Artificial Parts

Do you have?

Artificial heart valve..... Dentures..... Artificial hip.....

Others

Have you developed any medical illness or medical condition between you
 consultation and date of treatment?

Nature of illness/condition..... Date.....

Have you taken any medication not previously mentioned or not prescribed by the
 clinic between you consultation and date of treatment?

Medication..... Date.....

Are there any other illnesses or factors relating to yourself or your family which have
 not been covered in this form?

Nature of illness..... Date.....

**I DECLARE THAT THE ABOVE ANSWERS ARE, TO THE BEST OF MY
 KNOWLEDGE, CORRECT AND ACCURATE. IF THERE IS ANY FACTOR OF
 RELEVANCE TO ME OR MY FAMILY WHICH I HAVE NOT MENTIONED OR
 RECENTLY BECOME APPARENT I WILL INFORM DR.CONOR KIELY
 IMMEDIATELY.**

Signed:

Patient: _____

Date: _____

(dd/mm/yy)

Should you have any questions or need clarification on any aspect of The Medical
 Questionnaire please do not hesitate to contact Dr. Conor Kiely on 087 2869030 / 021
 436495