THE TAJ MEDICAL GROUP LIMITED
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YOUR HEALTH ASSESSMENT QUESTIONNAIRE Please carefully read, complete, sign and verify by your GP & return by email, post or fax.

Personal details:		
Name: Mr / Mrs/ Miss / Ms / Dr		
Address:		
Post code:		
Date of Birth:	Male or Female:	Email address:
Telephone number(s): Home:	Office:	Mobile:
Contact details of next of kin, family member or colleague:		

Please mark in the appropriate column and where an answer is 'yes' please provide further details. Please feel free to attach an additional sheet if necessary.

HAVE YOU EVER SUFFERED:	NO	YES	DETAILS:	HAVE YOU EVER SUFFERED:	NO	YES	DETAILS:
Angina?				Gall stones?			
Heart Attack?				Recurrent indigestion / heartburn?			
Other heart problems?				Stomach ulcer?			
High blood pressure?				Hernia?			
Irregular heart beat?				Recurrent diarrhoea / constipation?			
Stroke?				Other bowel problems?			
Ankle swelling?				Hepatitis?			
Pain in legs on walking?				Other liver problems / jaundice?			
Thrombosis (blood clots)?				Diabetes?			
Other circulation problems?				Thyroid problems?			
Shortness of breath?				Other glandular problems?			
Persistent cough?				Any tropical disease e.g. malaria?			
Coughing up blood?				Glaucoma/other eye/sight problems?			
Asthma?				Deafness/other ear hearing problems?			
Bronchitis?				Skin problems?			
Pneumonia?				Recurrent back ache?			
Other lung problems?				Other back problems?			
Tuberculosis?				Arthritis?			
Prostate problems?				Rheumatic fever?			
Kidney stones / disease?				Other joint problems?			
Other urinary problems?				Sciatica?			

PLEASE CONTINUE

HAVE YOU EVER:	NO	YES	DETAILS:
Had other nerve problems?			
Had epilepsv?			
Had anaemia?			
Had other blood problems?			
Had Gynaecology problems?			
Had cancer?			
Been diagnosed MRSA positive?			
Been in another hospital for longer than 24 hours in the last 12 months?			
Been diagnosed or suspected as having vCJD?			
Been a recipient of growth hormone or Gonadotropin?			
Been treated with steroids e.g. Prednisolone, hydrocortisone?			
Been treated with anticoagulant drugs e.g. Aspirin, warfarin?			
Had an anaesthetic?			
Reacted to a drug *I* anaesthetic?			
Reacted to latex (rubber) products? (i.e.. balloons, elastic, condoms)			
Reacted to poinsettia plants, avocados, bananas, tropical fruit (e.g. kiwi) or chestnuts?			
Had any other allergic reaction?			
Experienced itching, watery eyes, drowsiness, sneezing or runny nose after a dental appointment?			
Had a serious accident *I* injury?			
HAVE YOU A FAMILY HISTORY OF:	**NO**	**YES**	**DETAILS:**
Heart disease?			
High blood pressure?			
Stroke?			
Cancer?			
Diabetes?			
Blood disorders?			
Anaesthetic problems?			
DO YOU:	**NO**	**YES**	**DETAILS:**
Or have you ever smoked?			
Drink alcohol (how many units per week?)			
Have a cardiac pacemaker?			
Have any dental crowns, caps, bridges, artificial or loose teeth?			
Wear spectacles contact lenses *I* hearing aid?			
Have any physical disability?			

DO YOU:	NO	YES	DETAILS
Usually require any mobility aids in order to move around? (e.g. sticks/ frame/ wheelchair)			
Require a special diet?			
Have any other special needs?			

WHAT IS YOUR: WEIGHT: kg/lbs HEIGHT: ft/ins

LIST ALL PREVIOUS SURGERY, if ANY:

LIST ALL CURRENT MEDICATION BEING TAKEN, IF ANY:

PATIENT DECLARATION FOR HEALTHCARE FACILITATION

This declaration should be signed by the patient, if over 18, or by a parent/guardian if the patient is a minor, or by a spouse, adult children or parents if the patient lacks the ability to make an informed decision.

I acknowledge that, in compliance with the Data Protection act 1996, the information I have provide to THE TAJ MEDICAL GROUP LIMITED may be shared with hospitals and consultants during the course of health care facilitation.

I acknowledge that the hospital is providing their services directly to the patient and not on behalf of THE TAJ MEDICAL GROUP LIMITED. THE TAJ MEDICAL GROUP LIMITED does not itself offer any medical or legal advice, or any kind of insurance. Medical disputes regarding the nature of the procedure, or the quality of care provided, shall be dealt with in accordance with the local law prevailing in the country, in which the procedure was done. I understand the administrative role of THE TAJ MEDICAL GROUP LIMITED and hence I agree THE TAJ MEDICAL GROUP LIMITED is not responsible for the final outcome of the treatment or procedure.

I recognise that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.

I am aware that THE TAJ MEDICAL GROUP LIMITED is able to arrange for a private consultation in the UK both before and after my private treatment overseas and that this is their recommended course of action.

Cosmetic Surgery

I understand that the effects of cosmetic surgery may not be immediately visible. I understand that the affect of cosmetic surgery is much more limited for smokers, that mild asymmetry is normal and that the rate of healing will depend upon age, skin type, compliance with doctor's advice or factors beyond control.

I have read and fully understood the above declaration and the information I have provided in the health questionnaire is true and accurate to the best of my knowledge.

Patient Signature:..... Date:.....

Checked & Verified by General Practitioner: Date:.....

Full Name: Dr _____ Signature: _____

Practice Address & Telephone No.:_____

PLEASE CONTINUE

Please feel free to provide additional details, if required:

IF REQUIRED

PLEASE CONTINUE