

UK MEDICAL INFORMATION AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

Contact Information:

Address: _____

Phone Number: _____

Email: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Medical History:

Do you have any allergies? If yes, please list:

Do you have any chronic medical conditions? If yes, please specify:

Are you currently taking any medications? If yes, please list:

Have you had any surgeries or hospitalizations? If yes, please provide details:

Do you have any history of heart disease, stroke, or blood pressure issues?

Do you have diabetes or any endocrine disorders?

Do you have any respiratory conditions (e.g., asthma, COPD)?

Do you have any neurological or psychiatric conditions?

Have you ever had any infectious diseases currently or in the past year?

Are you pregnant or breastfeeding? (if applicable):

Consent and Declaration:

I hereby declare that the information provided above is accurate and complete to the best of my knowledge. I understand that withholding information or providing false information may affect my medical care. I consent to any medical examination, treatment, or procedure deemed necessary by medical professionals. I acknowledge that such treatments will be performed in accordance with UK law and professional standards. I confirm that I have had the opportunity to ask questions about my medical care and that these have been answered satisfactorily. I understand that my personal medical data will be processed and stored in compliance with the UK Data Protection Act 2018 and GDPR, solely for the purposes of providing healthcare.

Data Protection and Confidentiality:

All personal and medical information provided will be treated as strictly confidential and used solely for the purpose of delivering healthcare services. Information may be shared only with authorised personnel and organisations as permitted or required by UK law. Patients have the right to access their medical records and request corrections as stipulated by the Data Protection Act 2018.

Patient Rights and Responsibilities:

Patients have the right to respectful and professional care, to be informed about their health, and to participate in decisions regarding their treatment. It is the patient's responsibility to provide accurate and complete information, follow prescribed treatments, and respect the healthcare providers and premises.

Declaration and Signature:

Patient Signature: _____

Print Name: _____

Relationship to Patient (if signed by representative): _____

Date: _____

WITNESS SIGNATURE

WITNESS PRINT NAME

Signature: _____

Name: _____

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