

Patient Information Form

Medical History

Please complete this form and email, fax or post it to the rooms prior to your consultation.

NAME AND DATE OF BIRTH

Surname: First Name:

Date of birth:

MEDICAL HISTORY

Please indicate whether or not you have had the following conditions by ticking the 'yes' or 'no' boxes:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoker
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thrombosis
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy

ALLERGIES & CURRENT MEDICATION

List any allergies: Current Medication:
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PAST MEDICAL ILLNESSES

(if not listed above).....
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PREVIOUS SURGERY

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CURRENT PROBLEM

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