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MEDICAL HISTORY

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

Name & Contact Details:

Surname _____

First name _____

Date of birth _____

Number of pregnancies _____ Number of children _____

When was your last PAP smear? _____ Have you ever had a mamogram? Yes No

Please outline your current problem or concern: _____

Previous health:

Please tick if you have experienced any of the following

- | | |
|--|---|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis or other blood born infections |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gastric ulcer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thrombosis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Epilepsy |

Allergies: _____

Current medication: _____

Other illnesses: _____

Previous surgery: _____

Are there any illnesses that run in your family? _____
