CONFIDENTIAL MEDICAL BACKGROUND

Name__________________________________ Age____________ Today's date _______________

I would be grateful if you could complete this form which includes some background medical health information. It will help me to consider other factors which may be relevant to your current health problems.

Have you had any of the following?

Allergies or reactions to any medications…………	Yes ☐…No ☐…………………….….
Asthma or other breathing problems …………	Yes ☐…No ☐…………..…………
High blood pressure ………………………………..	Yes ☐…No ☐ ………………..………
Heart problems or chest pains ……………………..	Yes ☐…No ☐……………..………
Urinary problems of any sort……………………….	Yes ☐…No ☐…………..……………
Bowel problems of any sort ……………………….	Yes ☐…No ☐………….…..………
Diabetes ……………………………………………..…	Yes ☐…No ☐………….…..………
Stroke …………………………………………………	Yes ☐…No ☐………….…..………
Fits, funny turns or collapse………………………...	Yes ☐…No ☐………….…..………
Problems with "nerves", depression ……………...	Yes ☐…No ☐………….…..………
Duodenal ulcers or hiatus hernia ………………….	Yes ☐…No ☐………….…..………
Do you smoke?...	Yes ☐…No ☐………….…..………
Have you ever smoked regularly in the past?........	Yes ☐…No ☐………….…..………
Have you had a cholesterol test? (result……)……	Yes ☐…No ☐………….…..………
Any blood tests in the last 3 months ……………..	Yes ☐…No ☐………….…..………
Any x-rays or other tests in the last 3 months ……	Yes ☐…No ☐………….…..………

Previous operations ____

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Previous illnesses or hospitalizations ____

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Other General Practitioners or Specialists you have seen recently ______________________

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Major illnesses that your parents have or had ______________________________________

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List all current medications, including dose and number of times daily __________________

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