MEDICAL HISTORY FORM

All information provide is strictly confidential and will become part of your medical record.

Name:	**DOB:**
G.P.:	
Referring doctor:	

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed		
Surgery		
Year	Reason	Hospital
Hospitalisations		
Year	Reason	Hospital

Medications (it is important to include over the counter medications, vitamins and supplements		

Allergies to medications	
Name of Medication	Reaction you experienced