Please complete 1 form per patient/dependant

## **Patient Medical Information** (Please write legibly to ensure accurate data capturing)

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|---|---|---|---|
| PATIENT NAME: | | DATE OF BIRTH: | |
| ALLERGIES: | For example: drug allergies (penicillin, sulpha's, anti-inflammatories, etc.), food allergies, environmental allergies, etc. | | |
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| PAST SURGICAL HISTORY: | For example: appendectomy, broken bones, joint replacements, gall stones/gallbladder removal, sinus surgery, caesarean section, abdominal/bowel surgery, cancers, etc. | | |
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| PAST & CURRENT MEDICAL HISTORY: | For example: high blood pressure, high cholesterol, diabetes, thyroid problems, auto-immune conditions (like lupus or rheumatoid arthritis), heart attack, angina, stroke, mini stroke/TIA, heartburn, peptic ulcer, etc. | | |
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| CURRENT CHRONIC OR LONG-TERM MEDICATION: | Any prescription and non-prescription medications taken on a regular, daily basis, including the oral contraceptive pill | | |
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| GYNAECOLOGICAL & OBSTETRIC HISTORY: (FEMALES) | Pregnancies, miscarriages, number of children, delivery problems, pregnancy complications, etc. | | |
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| I do hereby declare that the above information is true and correct | | | |
| SIGNATURE: | | DATE | |

IF YOU ARE UNSURE OF ANY OF YOUR MEDICAL HISTORY OR MEDICAL TERMINOLOGY, PLEASE FEEL FREE TO DISCUSS THIS WITH THE NURSE OR DOCTOR.