PATIENT NAME: **Date of Consultation:**

MEDICAL HISTORY: Have you ever had …..(Tick all that apply)

_____Asthma/Breathing problems	_____ Cancer	_____ Radiation/Chemotherapy
_____Thyroid trouble	_____Hepatitis	_____Kidney disease
_____Tuberculosis	_____Seizures	_____Sleep apnoea
_____Heart Attack	_____AIDS or HIV	_____Stomach Ulcer
_____Fibromyalgia	_____Arthritis	_____High blood pressure
_____Low blood pressure	_____Varicose Veins	_____Blood clots
_____Stroke	_____Migraine or other severe head pain	
_____Irregular heart beat	_____Pacemaker	

Do you drink Alcohol? YES / NO How much?_____

Do you smoke? YES / NO How many? _____

_____Diabetes if **YES** - Insulin dependent _____ Non Insulin dependent _____

ALLERGIES:

Name of medicine/substance	**Type of reaction:**

Are you under the care of another Specialist:

Dr Name:	**Condition for Specialist treatment:**

MEDICINES: List all medicines that you take, including the doses and how often you take them. **Include vitamins and non-prescription medicine.**

1._____ 4._____

2._____5._____

3._____6._____