PERSONAL MEDICAL HISTORY

Please tick the box if you have/had any of the following illnesses

Heart problems	
Blood pressure	
Diabetes	
High cholesterol	
Rheumatic fever	
Thyroid problems	
Asthma/respiratory	
Stomach ulcers	
Cancer or tumour	
Kidney or liver problems	
Gout	
Tuberculosis	

Please answer the following questions

Do you have a pacemaker?	
Do you have a defibrillator?	
Do you smoke tobacco?	
How many do you smoke per day?	
When did you give up smoking?	
Do you drink alcohol?	
How much do you drink per day?	
Allergies (please specify)	
Do you have any chronic illnesses? (please specify)	

CURRENT MEDICATIONS

Please bring your current medications with you on day of consultation

Medication Name (eg. Lasix)	Strength (eg. 40mg)	Dose (eg. 1 morning and 1 midday)

LIST ANY PREVIOUS SURGICAL PROCEDURES

Date	Surgical procedure

Thank you for your help

Payment is preferred at time of consultation. Credit cards and cheques accepted, EFTPOS available