Pre-consultation Information form.

Please complete this form with your details and history, print it out, and bring it with you for your consultation. This will save us time and allow you to get more out of your consultation. Please bring all your medical documents, including blood tests, X-rays, CT scans, etc., with you when you come so we have complete information and can diagnose and treat you effectively.

Name: Date of Birth:

Address:

How Did You Find Dr Hiranandani?

Telephone No. Mobile No.

E-mail: Occupation .............................…

**Personal History:** Please list all the ailments you have at present and problems you have suffered from in the past. Please use an additional sheet if necessary. This information helps us to treat you fully.

**DISEASE PARTICULARS DURATION**

1 ................................................................................................................

2 ................................................................................................................

3 ................................................................................................................

4 ................................................................................................................

5 ................................................................................................................

6 ...............................................................................................................

7 ................................................................................................................

8 ................................................................................................................

9 ................................................................................................................

10................................................................................................................

11................................................................................................................

12................................................................................................................

**1.** Have You had any accidents or falls? Please give the year and details

2. Have you suffered from any major illnesses?

............................................................................................................................

3. Have you undergone any operations? If yes, please give us the Name and year of the operation.

............................................................................................................

………………………………………………………………………………………………

4. Is there any history of these Problems in your Family ………………. ……………………………………………….. ………………………….

5 . What medicines are you taking at present?

 Name Dosage Frequency

a................................................................................................................ b................................................................................................................

c................................................................................................................

d................................................................................................................

e................................................................................................................

f ...............................................................................................................

g................................................................................................................

h................................................................................................................

i. ..............................................................................................................

j................................................................................................................

k................................................................................................................

l ..............................................................................................................

m................................................................................................................

1. Are you allergic to any foods or medicines? If yes, Give details

Is there any other information you would like to give?