



Medical History				
Do you suffer from any of these conditions?			Is there a family history of these?	
	Yes/No	Your age at onset	Relationship to you	Their age at onset
High Blood Pressure				
Stroke				
Angina/Heart Attack				
Asthma				
Diabetes				
Epilepsy				
Mental Illness/Depression				
Cancer				
Other				

Please list any major illnesses, accidents or operations with approximate dates.

Immunisations			
	Yes	No	
Full Childhood Course including 2 doses MMR			
School Leaver's Booster			
BC G			
Date of last Tetanus Booster			

Women Only				
Method of contraception, if any				
Date of last cervical smear			Result	
Date of last mammogram			Result	
<b>Births</b>				
Date	Complications of Pregnancy	Problems of Delivery	Birth Weight	Sex of Child
<b>Miscarriages</b>				
Date	How many months	Womb scraped		