My medical history

Birth

Birth weight:_____
Were you born early? No □ Yes □ At how many weeks?
Any problems at birth?

Serious illnesses

Illness	Date/age	Length of illness

Hospitalisation and Surgeries

Date/age	Procedure/Why	Length of stay in hospital

Immunisations

Immunisation	Date 1	Date 2	Date 3
Diphtheria, tetanus, whooping cough (DTP)			
Polio (OPV or Sabin)			
Measles, Mumps, Rubella (German measles) (MMR)			

Family medical history

Condition	Relative
Cancer (type)	
Diabetes	
Heart disease	
High blood pressure	
Mental health condition (type)	

Adverse reactions to medications

Medication	Reaction/reason for no longer taking it?

Allergies

Food or substance	Reaction	Treatment

Treatments tried before?

Condition	Treatment	Outcome

My current medical conditions

Current medications

Medication	What is it taken for?	How much (dose)	How often is it taken?

Current GP

Name	
Practice address	
Phone number:	

Other healthcare professional(s)

Name	
Practice address	
Phone number:	

Name	
Practice address	
Phone number:	