PERSONAL AND FAMILY HISTORY FORM

Please print out and bring to your consultation
(Strictly Confidential)

PERSONAL HISTORY

Name _____

D.O.B _____ Relationship Status _____

PREGNANCY AND BIRTH

Do you know whether your mother suffered from any diseases or physical or emotional trauma while she was pregnant with you?

_____

_____

Was your own birth: normal long difficult breech

Were you breastfed? Yes No If yes, for how long? _____

INFANCY

Were there any problems when you were a baby that you know of? Eg colic, excessive crying, sleeplessness, feeding problems, constipation, failure to thrive.

_____

_____

At what ages did you ___ Teethe ___ Crawl _____ Walk _____Talk (months)

CHILDHOOD ILLNESSES

Did you suffer from recurring: Coughs/chest infections Ear infections
Tonsillitis/throat infections Stomach aches Skin problems

Any other illnesses _____

_____

What infectious childhood illnesses did you have? Were any particularly severe?

_____

_____

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OPERATIONS

Please give details of all operations to date:

_____

ACCIDENTS

Please give details of any serious accidents such as falls/burns/broken bones/injuries/etc:

_____

MEDICATIONS

Are you on any prescribed medication? Please indicate name of drug and dosage used and reason for prescription.

_____

_____

_____

FAMILY HISTORY

Mother:
Overall health _____

_____

Father:
Overall health _____

_____

IMMEDIATE FAMILY HISTORY: BROTHERS/SISTERS/GRANDPARENTS/ETC

Is there any family history of the following?

Asthma Cancer Diabetes If so which family member/s

_____

_____

Heart problems (High blood pressure/angina/strokes etc) If so which family member/s

_____

_____

Tuberculosis Mental illness (incl suicides) If so which family member/s

_____

_____

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