PATIENT CASE HISTORY FORM

PCH1P 6/2003 © Michael Thompson

Personal details	
First name	Last name
Address	
	Post code
Parents/Guardians Names (if appropriate)	
Date, place & time of birth (where known) / /	: am/pm @
Work phone	Home phone
Mobile	E-mail
Gender & Colour of eyes	Marital status
No. of children	Occupation
Height & Weight	Blood type A AB B O Rh positive Rh negative
Who recommended you? Yellow Pages/GP/Friend/Relative/Patient/Health Food shop/Other	
Form of consent: *I confirm that I have requested treatment*	
Date	Signature
General Practitioner (for our records only)	
Name	Phone
Have you seen your GP for your present condition & when was the last time?	

Present Illnesses & Problems (The conditions you might like help with)

Current Medication (name, dosage and what they are for)

Medical History

Operations (Please give your age and details of all operations)

Accidents (Please give details of any serious injuries? Do any of them still affect you now?)

Family Medical History

(What serious illnesses have your family had? Also the cause of any deaths and their ages)

Mother	Father
Sisters	Brothers