Dr (TCM) Attilio D'Alberto, BM (Beijing), BSc (Hons) TCM MBAcC MRCHM

Patient History Sheet

NAME .....

ADDRESS .....

MOB NO. ..... EMAIL .....

DATE OF BIRTH ..... AGE ..... SEX Male / Female

NATURE OF PROBLEM .....

DURATION OF PROBLEM ..... Days / Weeks / Months / Years

NAME & ADDRESS OF YOUR GP .....

.....

.....

OPERATIONS [with year or age at surgery]

eg TONSILLECTOMY AGE 9

.....

.....

MEDICAL PROBLEMS [with year or age at diagnosis]

eg ANGINA 1990

.....

.....

DO YOU HAVE ANY OF THE FOLLOWING? [please circle]

Asthma / Diabetes / Epilepsy / High or Low Blood Pressure / Anaemic / Heart Problems / Pacemaker / Metal Allergy / Pregnant / Deep Vein Thrombosis / Anti-Coagulants / Dizzy-Faint / Bruise Easily

DO YOU TAKE ANY DRUGS?

eg ASPIRIN 75mg every morning

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.....

.....

HAVE ANY ALLERGIES?

eg HAYFEVER

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.....

FAMILY HISTORY

eg FATHER Heart Attack

.....

.....

.....

.....

NON-SMOKER

EX-SMOKER ..... [years stopped]

SMOKER ..... [cigarettes per day]

ALCOHOL

Nil / Minimal / Moderate

OCCUPATION .....

STATUS Single / Co-habiting / Married / Separated / Widowed

HOW DID YOU HEAR ABOUT ME? .....

Please hand this directly to Dr (TCM) D'Alberto at your first consultation. **Thank you.**