Pre consultation Information form.

Please fill up this form with your personal details and history, Print it out & bring it with you for your consultation. This will save us time and allow you to get more out of your consultation. **Ple**ase share all your relevant medical documents with me, including blood tests, X-rays CT scans etc before your consultation so we have the maximum information to help diagnose & treat you effectively.

Your Name : Date of Birth :

Address:

How did you find Dr Hiranandani ?

Telephone No. Mobile No.

E-mail : Occupation .............................…

**Personal & past History:** Please list all the ailments you have at present as well as problems you have suffered from in the past. Please use an additional sheet if necessary. This information helps me to diagnose & treat you.

**DISEASE PARTICULARS DURATION**

1 ................................................................................................................

2 ................................................................................................................

3 ................................................................................................................

4 ................................................................................................................

5 ................................................................................................................

6 ...............................................................................................................

7 ................................................................................................................

8 ................................................................................................................

9 ................................................................................................................

10................................................................................................................

11................................................................................................................

12................................................................................................................

**1.** Have You had any accidents or falls please give year and details

2. Have you suffered from any major illnesses ?

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3. Have you undergone any operations .............. If yes, please give us the Name of & year of operations .................................................................................

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4. Do you suffer from Heart ailment, Diabetes or Hypertension. Is there any history of these Problems in your Family ……………………………………………….. ………………………….

5 . What medicines are you taking at present?.

 Name Dosage Frequency

a................................................................................................................ b................................................................................................................

c................................................................................................................

d................................................................................................................

e................................................................................................................

f ...............................................................................................................

g................................................................................................................

h................................................................................................................

i. ..............................................................................................................

j................................................................................................................

k................................................................................................................

l ..............................................................................................................

m................................................................................................................

1. Are you allergic to any foods or medicines? If yes Give details

7. What kind of food do you prefer bland/ mild spices/ medium spicy/ hot/diet.

8. Are you addicted to any substance like Tea/Coffee/Smoking/Alcohol/Zarda/ Pan Masala/ sleeping tablets etc. If so, give details.......................................

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Any other information you would like to give.

I certify that all the details given here are correct & true

Signed............................................

Dated: