

	Surname			D.O.B.	
	Given Name			Doctor	
	Preferred Name			Room Number	

**MEDICAL HISTORY
TO BE COMPLETED BY DOCTOR**

Diagnosis:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____

Past Significant Illnesses/Operations:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Medication:

- | | |
|---------|----------|
| 1 _____ | 6 _____ |
| 2 _____ | 7 _____ |
| 3 _____ | 8 _____ |
| 4 _____ | 9 _____ |
| 5 _____ | 10 _____ |

Allergies:

I have treated this patient for _____ years. I am / am not prepared to continue to consult with the patient whilst in residence at your centre.

Medical Practitioner: _____

Date: _____

N.B. Realising that it may be some time before entry, we may request a further medical assessment prior to entry.

 <i>Hill View House</i>	Surname			D.O.B.	
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Past / current medical history	
Respiratory	Skin
Renal.	G.I.T.
Cardiovascular.	Psychological
Endocrine	Pain
Neurological	Oral
Skeletal	Observations BP Pulse Respiration Reflexes
Comments	