# MY MEDICAL HISTORY

## My Current Medical History:

## Current Medications:

| Medication Name | What is it taken for? | How Much do I take? | How often do I take it? |
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## Allergies:

| Food/Substance/Medication | Reaction | Treatment |
|---|---|---|
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## Hospitalisation and/or surgery:

| Date/Age | Procedure/Reason | Length of Stay |
|---|---|---|
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## My Local Doctor (GP):

**NAME:**

**Practice Address:**

**Phone Number:**

| Patient Name: | Patient/Hospital No: | Date: |
|---|---|---|
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