Name:

Date of Birth:

Home Phone:
Mobile Phone:

Address:

Medication you are currently taking:

Name	What for?

Do you smoke?

Do you live with anyone that smokes?

Diagnosed Health Issues:
(Physical and Psychological)

Known Allergies:

Babies (only)

Breastfed: Yes or No

Age of weaning off breast milk?

Formula Fed: Yes or No

Formula Name:

Vaccines: Yes or No

Did baby get a fever/rash afterwards Vaccines? Yes or No

Symptoms

Upper Respiratory Tract:

	Tick if applies	When did it start?
Blocked Nose		
Sinus Problems		
Runny Nose		
Post Nasal Drip		
Hayfever		
Snoring		
Sore Throat		
Hoarseness		
Tonsillitis		

Lungs:

	Tick if applies	When did it start?
Cough		
Asthma		
Wheezing		

Digestive System:

	Tick if applies	When did it start?
Bloating		
Gassy		
Nausea		
Constipation		
Diarrhoea		
Reflux/Heartburn		
Pain in Stomach		

Skin:

	Tick if applies	When did it start?
Eczema		
Itchy Skin		
Rash		
Psoriasis		
Spots		

Appointment Date: Paid: Yes or No