PATIENT SAFETY ALLIANCE

MY MEDICAL HISTORY

TOOL 1

NAME:_____

Date of birth:_____ I am allergic to _____

1) I am suffering from: (Enlist the chronic diseases that you have)

Name of Disease	Since when are you suffering	Doctor who has treated	Medicines that you take
High Blood Pressure			
Diabetes			
Hypothyroidism			
Asthama			
Tuberculosis			

3) I was admitted for

Diagnosis/ Name of surgery	Year when admitted	Any complication	Name of doctor/hospital

4) I have already taken these immunization shots:

Name of vaccine	Taken for	When did you take it?

5) My family members have / had following problems:

Relation with the family member	Suffering from	Alive and healthy?

6) any other additional information you want to give?

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