DR ALLIE MOHAMED

Maxillo-Facial and Oral Surgeon

BChD, MChD MFOS (UWC), FCMFOS (SA), AOCMF Fellowship (Hannover) | Practice number 0571466

NAME : ____

FAMILY DOCTOR: ______________________

TEL : ______________________

MEDICAL HISTORY : To your knowledge, do you, or have you ever had any of the following (Tick Y/N):

	Y	N		Y	N		Y	N
Recent cold			Chest tightness [angina]			Back problems		
Cough or lung problem			Heart murmur			Vision problems		
Asthma, wheezing			Heart attack			Hearing problems		
Shortness of breath			Rheumatic fever			Liver disease, jaundice		
Stomach ulcer			Chronic heartburn			Kidney disorder		
Thyroid disorder			High blood pressure			Diabetes		
Sleep disorders			Stroke			Blood transfusion		
Multiple sclerosis			Anaemia			Hepatitis		
Epilepsy			Blood clots			Tuberculosis		
Skin problems			Bleeding or bruising			HIV/AIDS/STD's		

Any other medical complaints: ____

Allergies [if any]:____

Previous hospitalisations [if any]: ______________________________________

Do you smoke? Yes ☐ No ☐

Are you pregnant? Not applicable ☐ Yes ☐ No ☐

List any medication or drugs you may be currently on:

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Suite 104a, East Suites, Mediclinic Constantiaberg
T: 021 761 0738 | F: 088 021 761 0738 | E: dralliemohamed@gmail.com