

(o) Please advise the name and address of the doctor who has confirmed the diagnosis of Disseminated Intravascular Coagulation.

(p) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

- (i) Name of referral doctor: _____
(ii) Name of clinic/ hospital: _____
(iii) Date referred: _____

(b) Did the patient consult other doctors for this illness or its symptoms before she consulted you?

Yes No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(c) Is the patient suffering or has suffered from any other significant illnesses? Yes No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

