Health Questionnaire

Name: _____DOB: _____

Address:_____

Phone: _____ Email: _____

Occupation:

_____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reasons for your appointment:

1._____

_____

2._____

_____

3._____

_____

Medical history or surgery:

_____

_____

_____

_____

_____

Health Questionnaire

Are you receiving any current medical treatment?

_____

_____

_____

_____

_____

Are you on any medications?

_____

_____

_____

_____

List any supplements that you are taking:

_____

_____

_____

Health Questionnaire

Gastro-intestinal	Respiratory	Immune system
□ Bowel movement daily □ Constipation □ Diarrhoea □ Flatulence □ Reflux/Heartburn □ Indigestion □ Nausea □ Abdominal pain □ Allergies □ Food intolerances	□ Persistent cough □ Asthma □ Post nasal drip □ Sore throat □ Ear infections □ Recurring tonsilitis □ Nasal congestion □ sinusitis	□ Recurrent cold/flu □ Constant fatigue □ Poor wound healing □ Cold sores □ Mouth ulcers □ Recurrent infections □ Swollen lymph nodes □ Auto immune disease
Skin	**Musculoskeletal**	**Cardiovascular**
□ Poor wound healing □ Acne □ Psoriasis □ Dry, flaky skin □ Oily skin □ Eczema / skin rashes	□ Headaches □ Migraines □ Muscle aches or cramps □ Joint pain □ Restless legs □ Muscle weakness	□ High blood pressure □ High cholesterol □ Easy bruising or bleeding □ Palpitations □ Dizziness □ Varicose veins
Urinary	**Endocrine**	**Perimenepause**
□ Frequent urination □ Pain with urination □ Incontinence □ Blood in the urine □ Urinary tract infection	□ Fatigue/low energy □ Heat/cold intolerance □ Hair falling out □ Abdominal weight gain □ Thyroid disorder	□ Hot flushes □ Night sweats □ Change in menstrual cycle □ Dry hair, skin or vagina □ Low libido □ Breast tenderness □ Depressed or teary □ Anxious or irritable □ Food cravings □ Fluid retention/bloating □ Headaches or migraines □ Joint pain
Menstrual symptoms	**Sleep**	**Lifestyle**
□ Pre menstrual tension □ Depressed/anxious □ Irritable □ Breast tenderness □ Food cravings □ Fluid retention/bloating □ Headaches or migraines □ Long intervals between cycles □ No period □ Cycles of less than 17 days □ Heavy blood flow □ Very light blood flow □ Spotting between cycles □ Period pain	□ Sleep each night ___hours □ Difficulty falling asleep □ Do you wake refreshed? □ Do you wake during the night? □ Do you remember your dreams?	□ Smoker □ Coffee _____/ day □ Tea _____/day □ Water _____/day □ Alcohol _____ /week □ Recreational drugs □ Exercise ___ / week □ Excessive plane travel □ High stress levels

3 Day Food Diary

Write down everything you eat and drink. Include the amount of the food and list brand names of foods you bought. List exact ingredients of homemade foods and whether the food is packaged or takeaway. The purpose of this diary is not to judge your eating habits, but to learn more about your nutritional needs and strengths.

Day1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Morning snack	Morning snack	Morning snack
Lunch	Lunch	Lunch
Afternoon tea	Afternoon tea	Afternoon tea
Dinner	Dinner	Dinner