CONFIDENTIAL PATIENT QUESTIONNAIRE Date:

Name	DOB	Email

Reason for Visit

Past Medical History- include operations, illnesses and investigations

Allergies/Sensitivities- include medications, foods, dustmite, grasses , chemicals

Allergy/Sensitivity	Reaction/treatment

Current Medications-include name and dose

Nutritional Supplements, Vitamins, Herbal or Homeopathic Remedies

Have you suffered from any of the following? (Circle):

Allergies	Asthma	Hay fever	Sinusitis	Eczema	Kidney or bladder problems
Bronchitis	Emphysema	Diabetes	Skin Problem	Epilepsy	Fits or convulsions
Gallstones	Hepatitis	Jaundice	Thyroid Disease	Meningitis	Nervous Problems
Angina	Heart Disease	Hypertension	STD’s	Diarrhea	Smell or taste problem
PMT	Pneumonia	Hernia	Tuberculosis	Malaria	Vision or eye problems

Family Medical History
Has any member of your family ever suffered from? (Circle)

Asthma	Gout	Diabetes	Heart disease	Kidney Trouble
Arthritis	Allergies	Hay Fever	Mental Problems	Fits or Turns
Cancer	Stroke	Glaucoma	Nervous trouble	Defective hearing
Epilepsy	Tuberculosis	Hypertension	Thyroid Disease	Dementia

Family History Continued:

	Father	Mother	Sisters	Brothers	Wife/Husband	Children
Age(if living)						
State of health						
Age of death						
Cause of death						

Social History

Occupation	
Marital Status	
Cigarettes/tobacco (Strength& amount/day)	
Are you an ex-smoker?	
Alcohol (type & amount per week)	
Recreational Drugs	
Exercise (type, duration and frequency)	
Do you know how to relax? (eg meditation, yoga)	
Do you sleep well?	
Do you crave any foods? List	
Have you had any dental treatment recently?	
Have you been overseas recently?	
Do you have pets? (Are they wormed regularly?)	
Are you exposed to chemicals, leads, sprays paints solvents or anything else that can be toxic?	

Preventative Medicine

Has your blood pressure been checked in the past 12 months?	Yes	No
Has your cholesterol been checked in the last 5 years?	Yes	No
Has your blood sugar been checked in the last 2 years?	Yes	No
Have you had any bleeding form the bowel/bladder?	Yes	No
Do you have any skin lesions checked regularly?	Yes	No

Female

Have you had a Pap smear in the last 2 years?	Yes	No
Have you had a breast exam in the last 12 months?		
If you are over 50 have you had a mammogram in the last 12 months?		
Are you post menopausal and had any vaginal bleeding?		

When was the last time you felt truly well?

What do you expect from your consultation today?

 Thank you for completing this form