MICHELLE TOOCARAM ST IVES HEALTH CLINIC
CONFIDENTIAL PATIENT HISTORY QUESTIONNAIRE

SURNAME……FIRST……TITLE……

ADDRESS…… SUBURB……

POSTCODE…… REFERRED BY…….

PHONE: HOME……WORK……MOBILE……

EMAIL : ……DATE OF BIRTH……

OCCUPATION…… HEALTH FUND …… STATUS: SINGLE /

MARRIED/ DIVORCED /SEPERATED /WIDOWED /DE FACTO

CHILDREN/AGES……

REASON FOR YOUR VISIT?……

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CURRENT SUPPLEMENTS & MEDICATIONS……..

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MAJOR HEALTH EVENTS……

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EXERCISE/FREQUENCY ……

HOW DO YOU SLEEP?……

WATER INTAKE?…… OTHER FLUIDS ……

BLOOD PRESSURE: NORMAL/LOW/HIGH ENERGY LEVEL (1-10, where 10 is HIGH) ……

BOWEL MOVEMENTS (per day)…… URINE (times per day)……

DIGESTION/APPETITE……..

MENSTRUATION ……

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VACCINES & DATE ……..

TEETH List all problems including any amalgams or root canals (which tooth)etc,
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HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Circle all that apply and note any other health issues:

- Arthritis/Joint problems
- Asthma / bronchitis / breathing difficulties
- Bowel problems
- Cancer
- Cholesterol, high
- Chronic fatigue / Fibromyalgia
- Circulation problems
- Diabetes
- Dizziness / Nausea / Fainting
- Depression or Anxiety
- Digestive problems
- Epilepsy
- Headaches/migraine
- Heart disease
- HIV / Aids
- Osteoporosis / bone fractures
- Pregnancies / Miscarriages/ Caesarians
- Skin problems
- Thrombosis / Clots/Stroke
- Thyroid hyper or hypo

OTHER HEALTH ISSUES ……..

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FAMILY MEDICAL HISTORY ……

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RELATIONSHIPS (Partner/Parents/Siblings/Friends)……

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