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……

SCHOOL…… HEALTH FUND……

REASON FOR YOUR

VISIT?……

……

……

CURRENT SUPPLEMENTS & MEDICATION……

……

MAJOR HEALTH EVENTS……

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/OTHER)……

…… …… ……

URINE (times per day/OTHER)……

DIGESTION/APPETITE……

……

VACCINES & DATES……

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
- Circulation problems
- Diabetes
- Dizziness / Nausea / Fainting
- Depression or Anxiety
- Digestive problems
- Epilepsy
- Headaches/migraine
- Heart disease
- Infections
- Bone fractures
- Worms
- Skin problems
- Bed wetting
- Thyroid

OTHER……

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