MICHELLE TOOCARAM ST IVES HEALTH CLINIC
CONFIDENTIAL PATIENT HISTORY QUESTIONNAIRE

SURNAME……FIRST……TITLE……

ADDRESS…… POSTCODE……

REFERRED BY……

PHONE: HOME……WORK……MOBILE……

EMAIL : …… DATE OF BIRTH……

OCCUPATION…… HEALTH FUND……

STATUS: SINGLE/MARRIED/ DIVORCED/SEPERATED/WIDOWED

CHILDREN/AGES……

REASON FOR YOUR VISIT?.

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CURRENT SUPPLEMENTS & MEDICATION.

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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…….

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VACCINES (Dates)…….

TEETH any root canals or amalgams, if so which teeth…….

ANTIBIOTICS frequency of use……

…….

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
- Skin problems
- Thrombosis / Clots/Stroke
- Thyroid hyper or hypo

OTHER……

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RELATIONSHIPS……

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