



CONFIDENTIAL PATIENT QUESTIONNAIRE

Please complete the following questionnaire. Your response remains confidential and will provide information for your practitioner to use in your assessment and treatment.

Practitioner: _____ Appointment Date: ____/____/____ Time: ____:____

Title		Date of Birth		
First / Second Names		Surname		
Home Address				
Suburb/Town		State		Postcode
Home: ()		Work: ()		Mobile:
Medicare Number		Ref (exp.)		Private Health Fund
Email Address				
Height (cm)		Weight (kg)		
Next of Kin		Relationship		Telephone No:
How did you hear about YourHealth? Please circle the category below.				
Advertisement	Article	Brochure-Flyer-Poster	Direct Mail	Email Newsletter
Expo-Conference	Friend-Relative-Colleague	Pharmacy-Health food store	Orion Corporate Health	Pharmacy / Health food store
Practitioner referral	Seminar	TV / Radio	Walk-by-Signage	Website
Local GP Details if applicable		GP Name		
GP Address		GP Phone Number		

GENERAL DETAILS

Please list the main problems you are experiencing and/or reasons for this appointment.

What do you believe the problem may be due to?



What kind of treatment(s) have you tried for the problem(s) listed above? *Please detail any relevant testing or investigations and bring relevant copies with you to your consultation.*

When was the last time you felt truly well?

What do you expect from your consultation today?

What do you think can help you?

PAST MEDICAL HISTORY

Please circle as appropriate.

Illness/Medical Problem	Present	Past
Heart/Vascular Disorder	YES	YES
Blood disorder	YES	YES
High blood pressure	YES	YES
Cancer	YES	YES
Arthritis	YES	YES



Diabetes	YES	YES
Liver disease	YES	YES
Kidney disease	YES	YES
Asthma	YES	YES
Epilepsy	YES	YES
Hepatitis	YES	YES
Glandular fever	YES	YES
Dysentery	YES	YES
Sexually Transmitted Diseases <i>Please specify.</i>	YES	YES
Other conditions <i>Please specify.</i>	YES	YES
Operations <i>Please specify.</i>	YES / NO	YES / NO
Pregnancies	YES / NO	YES / NO
Exposure to chemicals or toxins <i>Please specify.</i>	YES / NO	YES / NO
Amalgam fillings	YES / NO	YES / NO
Frequent Antibiotic Use	YES / NO	YES / NO
Previous long-term medications (including contraceptive pill)	YES / NO	YES / NO

SCREENING/PATHOLOGY HISTORY

Screening Test / Pathology	Date	Result
Mammogram / Breast Ultrasound		
Pap Smear		
Bone Density		
Cholesterol		
PSA (Prostate Blood Test)		



NUTRITIONAL SUPPLEMENTS (vitamins, minerals etc.), HERBAL MEDICINES, HOMOEOPATHIC REMEDIES

Name	Dosage

CURRENT MEDICATIONS (prescription and non-prescription)

Name	Dosage

ALLERGIES / SENSITIVITIES (including medications, foods, dust mites, grasses, chemicals)

Allergies / Sensitivities	Treatment

SOCIAL HISTORY

Occupation	
Marital Status	
Cigarettes / Tobacco (strength & amount/day)	



Alcohol (type & amount/day)	
Recreational Drugs	
Exercise (type, duration & frequency)	
Relaxation Techniques (e.g. meditation, yoga, tai chi)	

DIET

Do you follow a specific type of diet? <i>Please circle.</i>	YES / NO
If yes, please specify. (eg. Low fat, low carbohydrate, blood group, vegetarian etc.)	

What did you eat yesterday? *Please complete the table below.*

Breakfast			
Lunch			
Dinner			
Snacks			
Sugar (tsp/day)	Tea (cups/day)	Coffee (cups/day)	Soft Drinks(per day)
Water (glasses/day)		Other Drinks	

Was this a typical day? *Please circle.* YES / NO

Please list the foods that you CRAVE .	Please list the foods that you AVOID .

IMMUNISATION HISTORY Please record any immunisations you have received.

TYPE	DATE	TYPE	DATE



CURRENT SYMPTOMS

Please tick the box to the right of any condition you are **CURRENTLY EXPERIENCING**.

GENERAL		WEIGHT		NERVOUS SYSTEM		EYES		EARS	
Fatigue		Weight gain		Headaches		Watery/itchy		Itchy	
Apathy/lethargy		Difficulty losing weight		Migraines		Painful/red		Ear aches	
Hyperactivity		Fluid retention		Faintness		Sticky eyelids		Infections	
Poor appetite		Binge eating		Dizziness		Blurred vision		Discharge	
Hypoglycaemia		Compulsive eating		Numbness		Deteriorating vision		Tinnitus (ringing)	
Poor sleep/insomnia		Craving for certain foods		Tingling, pins & needles		Dry eyes		Hearing loss	
Sleep apnoea		Weight loss		Poor co-ordination					
Excessive thirst		Eating disorders		Feel cold easily					
Stress				Cold hands & feet					
Easy bruising									

DIGESTIVE SYSTEM		HEART/CIRCULATION		LUNGS		GYNAECOLOGICAL		GENITO-URINARY	
Indigestion		High blood pressure		Shortness of breath		PMT (premenstrual)		Frequent urination	
Heartburn/reflux		Low blood pressure		Cough		Breast pain		Passing large amounts of urine	
Bloating		High cholesterol		Sputum		Breast lumps		Burning / discomfort on urination	
Feel full easily		Chest pain		Blood		Breast implants		Discharge	
Burping		Palpitations/arrhythmia		Chest tightness		Regular periods		Blood in urine	
Flatulence		Swelling of ankles		Wheeze		Irregular periods		Urgent urination	
Abdominal/stomach pains or cramps		Poor circulation				No periods		Kidney pain	
Nausea		Calf pain with exercise				Heavy periods		Difficulty passing urine	
Vomiting		Varicose veins				Menstrual clots		Passing urine frequently at night	
Difficulty swallowing						Period pain/cramps		Incontinence	
Diarrhoea						Painful intercourse		Loss of libido	
Constipation						Vaginal irritation/soreness		Erectile dysfunction (impotence)	
Piles (haemorrhoids)						Vaginal discharge			
Mucus						Thrush			
Rectal bleeding						Menopausal			
Anal itching						Hot flushes			
						Sweats			
						Vaginal dryness			
						Irregular bleeding/spotting between periods			
						Post coital bleeding			



NOSE		MOUTH / THROAT		SKIN		HAIR / NAILS		JOINTS / MUSCLES	
Congested/blocked		Mouth ulcers		Acne/pimples		HAIR		Pain	
Poor sense of smell		Cold sores		Eczema/dermatitis		Dry Hair		Swelling	
Sinus problems		Cracks at corner of mouth		Psoriasis		Increased hair loss		Stiffness	
Hay fever/allergy		Sore throat		Rosacea				Arthritis	
Sneezing		Hoarseness, loss of voice		Rashes		NAILS		Neck problems	
Excessive mucus		Gum disease/bleeding		Hives/urticaria		Soft		Back problems	
Post-nasal drip		Feeling of lump in throat		Dry skin		Break easily		Cramps / spasms	
		Loss of taste sensation		Poor healing		White spots		Muscle twitching	
		Bad breath		Excessive sweating		Ridged		Muscle tension	
				Body odour		Fungal infections		Muscle weakness	
				Dandruff				Gout	

EMOTIONS		MIND	
Anxiety		Poor memory	
Depression		Poor concentration	
Mood swings		Confusion	
Panic attacks		Poor comprehension	
Anger, irritability		'Brain fog'	



Please complete the chart below indicating only chronic or significant illnesses (eg. Cancer, diabetes, asthma, arthritis, heart disease and blood pressure) within the appropriate box on the family medical history tree.

FAMILY HISTORY





METABOLIC SCREENING QUESTIONNAIRE

Please rate each of the following symptoms based upon your health profile for the past 30 days.

0 = Never or almost never have the symptom.

1 = Occasionally have it, effect is not severe.

2 = Occasionally have it, effect is severe.

3 = Frequently have it, effect is not severe.

4 = Frequently have it, effect is severe.

DIGESTIVE TRACT	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, or passing gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal / Stomach pain	Total <hr/>
EARS	<input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, ear infections <input type="checkbox"/> Drainage from ears <input type="checkbox"/> Ring in ears, hearing loss	Total <hr/>
EMOTIONS	<input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear or nervousness <input type="checkbox"/> Anger, irritability, or aggressiveness <input type="checkbox"/> Depression	Total <hr/>
ENERGY / ACTIVITY	<input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Total <hr/>
EYES	<input type="checkbox"/> Watery or itchy eyes <input type="checkbox"/> Swollen, reddened or sticky eyelids <input type="checkbox"/> Bags or dark circles under eyes <input type="checkbox"/> Blurred or tunnel vision (does not include near or far sightedness)	Total <hr/>
HEAD	<input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Total <hr/>
HEART	<input type="checkbox"/> Irregular or skipped heartbeat <input type="checkbox"/> Rapid or pounding heartbeat <input type="checkbox"/> Chestpain	Total <hr/>
JOINTS / MUSCLES	<input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limitation of movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness	Total <hr/>
LUNGS	<input type="checkbox"/> Chest congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing	Total <hr/>



MIND	<input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion poor comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor physical co ordination <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities	Total _____
MOUTH / THROAT	<input type="checkbox"/> Chronic coughing <input type="checkbox"/> Gagging, frequent need to clear throat <input type="checkbox"/> Sore throat, hoarseness, loss of voice <input type="checkbox"/> Swollen or discoloured tongue gums, lips <input type="checkbox"/> Canker sores	Total _____
NOSE	<input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucus formation	Total _____
SKIN	<input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes, or dry skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Flushing or hot flushes <input type="checkbox"/> Excessive sweating	Total _____
WEIGHT	<input type="checkbox"/> Binge eating / drinking <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight	Total _____
OTHER	<input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> Genital itch or discharge	Total _____
GRAND TOTAL		_____
COMMENTS:	 	



General Acknowledgement and Consent Form

I, _____,

understand that some of the diagnostic tests, treatments and products administered by practitioners at **YourHealth Manly** may be outside the parameters of conventional medicine in Australia. They fall into the category of Natural or Complementary Medicine. I understand that these diagnostic tests, treatments and products are supported by empirical knowledge, are safe, are widely and successfully used by Integrative Medical practitioners in centres in Australia and overseas, and are only prescribed with utmost care. Some diagnostic tests and treatments offered at YourHealth centres are not covered by Medicare or private health insurance funds. All YourHealth practitioners are members and active participants of their respective professional Colleges and Associations.

I am attending YourHealth Manly of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me. I understand that YourHealth practitioners may recommend and dispense items that are yet to be regulated by the Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, the YourHealth practitioner(s) will make me fully aware of those risks and provide me with sufficient information to make an informed decision.

Signed,

Signature:

Date:

Management of Patient Health Information

This medical centre collects information from you for the primary purpose of providing quality health care.

We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also collect, hold, use and disclose the information you provide in accordance with IPN Medical Centre's Privacy Policy (the Centre's Privacy Policy). A copy of the Centre's Privacy Policy is available at the Centre's reception or can be obtained at the IPN's website (<https://www.ipn.com.au/about/privacy-policy.html>)

The Centre may collect, hold, use or disclose your personal information for purposes including but not limited to:

- Patient Satisfaction Surveys;
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements;
- To update our records and keep your contact details up to date;
- To communicate with you regarding appointments reminders, recalls and services which may be of interest to you;
- Health service promotions including important health messages;
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice;
- De-identified disclosure for research and quality assurance activities to improve individual and community health care and practice management

I consent to personal information being collected, held, used and disclosed in accordance with the Centre's Privacy Policy

Signature _____

Date: _____