

# Health Questionnaire Please complete all 3 pages



Name: .....

## What is the *main reason* for attending our clinic?.....

Please tick the appropriate column

<b>Topic</b>	Have you had.....	never	In the past	Recently	frequently
<b>Digestion</b>	Heartburn or reflux				
	Bloating after meals				
	Constipation				
	Burping, Farting or wind				
	diarrhoea or loose stools				
	Nausea (feeling like vomiting)				
	Stomach ulcers or Stomach pain				
<b>Lung</b>	Gall bladder problems				
	Asthma or Emphysema				
	Pneumonia or Bronchitis				
	Wheeze after viral infection				
<b>Immune system</b>	Wheeze after exercise				
	Boils				
	Cold sores				
	Conjunctivitis				
	Ear infection				
	Genital infection				
	Mouth ulcers				
	Sinus infection				
	Sore throat				
	Thrush				
	Tonsillitis				
	Urinary infection				
	<b>Skin, Hair &amp; Nails</b>	Acne or pimples			
Brittle nails					
Dry eyes or mouth					
Dry skin					
Eczema or Dermatitis					
Hair loss					
Psoriasis					
Rashes					
Sore or cracked lips					
Tinea or ringworm					
Warts					

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Do you have allergies?		No	Yes	
Allergy	Medications			list .....
	Foods or herbs			list .....
	Hay fever or sinus trouble			
	Nasal blockage			
	Other			list .....

<b>Gynaecological</b>	never	In the past	Recently	frequently
Abnormal PAP smears				
Breast Cyst or lumps				
Breast tenderness				
Endometriosis				
Fibroids				
Ovarian cysts				
PMS/PMT				
been on HRT				
been on oral contraceptive				

<b>Urinary</b>	never	In the past	Recently	frequently
Cystitis or Kidney infection				
Prolapse				
Stones				

<b>Any Liver problems?</b>	No	Yes	Year
Hepatitis or Jaundice			
Abnormal liver function tests			
Liver damage or Fatty liver			

		never	In the past	Recently	frequently
Heart	Angina or Chest pain				
	cold hands & feet				
	Fluid retention				
	Heart Attack				
	Heart failure				
	Heart murmur				
	High blood pressure				
	Palpitations or Irregular heart rate				

		never	In the past	Recently	frequently
Sleep	disrupted sleep				
	insomnia				
	snoring				
	unrefreshed sleep				

	Have you had.....	never	In the past	Recently	frequently
<b>Nervous system</b> <b>Muscle system</b>	Agitation or Anxiety				
	Blurred vision				
	Chronic pain				
	Depression				
	Dizziness or Vertigo				
	Facial twitching				
	fidgeting or Restless legs				
	Fits or seizures				
	Leg/foot or hand cramps				
	loss of balance				
	Memory loss				
	Migraine or other headache				
	Mood swings or Irritability				
	Muscle pain				
	Muscle weakness/heaviness				
	Pins & needles / Numbness				
	Poor concentration				
	Tinnitus (ringing in the ears)				
	Tremor of the hands				
	Weakness of a limb				

Have you ever had an accident?		No	Yes
Accident	Car		
	Plane		
	Motorcycle		
	Marine		
	Bicycle		
	industrial work		
	Sporting		
Weight	Overweight		
	anorexia bulimia		
	weight loss		



Have you ever suffered from.....		No	Yes
Blood disorders	Anaemia		
	Low Platelet count		
	Iron deficiency		
	Easy bruising		
	Low White cell count		

Have you had blood clots?			
Blood clot	Deep vein thrombosis		
	Pulmonary embolus		
Have you ever suffered from.....			
	Osteo Arthritis		
	Rheumatoid arthritis		
	Gout		
	Lupus		
	Ankylosing spondylitis		
	other		

Have you had cancer?

Cancer  
Melanoma or other skin  
Breast  
Ovary or uterus  
Lung  
Lymphoma or leukaemia  
Stomach or Colon  
Other

No	Yes	Year

list .....

Have you ever had

Candida  
Chronic fatigue/fibromyalgia  
Helicobacter infection  
Glandular fever  
Leaky Gut Syndrome  
Mycoplasma  
Oral or genital herpes  
Ross River Virus  
Shingles

No	Yes	Year

Do you have any of these?

Hormone  
Diabetes  
Thyroid problems

No	Yes

Do you take any prescription drugs? If so, please list them .....

Do you take any naturopathics ? If so, please list them .....

Do you know your blood group? .....

Do you take any vitamin/ mineral supplements? If so, please list them .....

Have you had any operations? If so please list them .....

Have you been on medication in the past? If so list them .....

Do any foods upset you?.....

Are there any diseases that run strongly in your family?.....

Are you vegetarian?.....

How many doctors have you seen about your problem so far? .....

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