

# Health Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation:  
\_\_\_\_\_

Name of GP: \_\_\_\_\_ Suburb: \_\_\_\_\_

Name of Specialist: \_\_\_\_\_ Suburb: \_\_\_\_\_

Specific reasons for your appointment:

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

Medical history or surgery:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Health Questionnaire

Are you receiving any current medical treatment?

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Are you on any medications?

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List any supplements that you are taking:

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## Health Questionnaire

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| <p style="text-align: center;"><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bowel movement daily</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhoea</li> <li><input type="checkbox"/> Flatulence</li> <li><input type="checkbox"/> Reflux/Heartburn</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Abdominal pain</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Food intolerances</li> </ul>   | <p style="text-align: center;"><u>Respiratory</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Post nasal drip</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Ear infections</li> <li><input type="checkbox"/> Recurring tonsillitis</li> <li><input type="checkbox"/> Nasal congestion</li> <li><input type="checkbox"/> sinusitis</li> </ul> | <p style="text-align: center;"><u>Immune system</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Recurrent cold/flu</li> <li><input type="checkbox"/> Constant fatigue</li> <li><input type="checkbox"/> Poor wound healing</li> <li><input type="checkbox"/> Cold sores</li> <li><input type="checkbox"/> Mouth ulcers</li> <li><input type="checkbox"/> Recurrent infections</li> <li><input type="checkbox"/> Swollen lymph nodes</li> <li><input type="checkbox"/> Auto immune disease</li> </ul>   |
| <p style="text-align: center;"><u>Skin</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Poor wound healing</li> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Psoriasis</li> <li><input type="checkbox"/> Dry, flaky skin</li> <li><input type="checkbox"/> Oily skin</li> <li><input type="checkbox"/> Eczema / skin rashes</li> </ul>   | <p style="text-align: center;"><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Migraines</li> <li><input type="checkbox"/> Muscle aches or cramps</li> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Restless legs</li> <li><input type="checkbox"/> Muscle weakness</li> </ul>   | <p style="text-align: center;"><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> High cholesterol</li> <li><input type="checkbox"/> Easy bruising or bleeding</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Varicose veins</li> </ul>   |
| <p style="text-align: center;"><u>Urinary</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Pain with urination</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Blood in the urine</li> <li><input type="checkbox"/> Urinary tract infection</li> </ul>  | <p style="text-align: center;"><u>Endocrine</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fatigue/low energy</li> <li><input type="checkbox"/> Heat/cold intolerance</li> <li><input type="checkbox"/> Hair falling out</li> <li><input type="checkbox"/> Abdominal weight gain</li> <li><input type="checkbox"/> Thyroid disorder</li> </ul>  | <p style="text-align: center;"><u>Perimenopause</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hot flushes</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Change in menstrual cycle</li> <li><input type="checkbox"/> Dry hair, skin or vagina</li> <li><input type="checkbox"/> Low libido</li> <li><input type="checkbox"/> Breast tenderness</li> <li><input type="checkbox"/> Depressed or teary</li> <li><input type="checkbox"/> Anxious or irritable</li> <li><input type="checkbox"/> Food cravings</li> <li><input type="checkbox"/> Fluid retention/bloating</li> <li><input type="checkbox"/> Headaches or migraines</li> <li><input type="checkbox"/> Joint pain</li> </ul> |
| <p style="text-align: center;"><u>Menstrual symptoms</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pre menstrual tension</li> <li><input type="checkbox"/> Depressed/anxious</li> <li><input type="checkbox"/> Irritable</li> <li><input type="checkbox"/> Breast tenderness</li> <li><input type="checkbox"/> Food cravings</li> <li><input type="checkbox"/> Fluid retention/bloating</li> <li><input type="checkbox"/> Headaches or migraines</li> <li><input type="checkbox"/> Long intervals between cycles</li> <li><input type="checkbox"/> No period</li> <li><input type="checkbox"/> Cycles of less than 17 days</li> <li><input type="checkbox"/> Heavy blood flow</li> <li><input type="checkbox"/> Very light blood flow</li> <li><input type="checkbox"/> Spotting between cycles</li> <li><input type="checkbox"/> Period pain</li> </ul> | <p style="text-align: center;"><u>Sleep</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sleep each night ___ hours</li> <li><input type="checkbox"/> Difficulty falling asleep</li> <li><input type="checkbox"/> Do you wake refreshed?</li> <li><input type="checkbox"/> Do you wake during the night?</li> <li><input type="checkbox"/> Do you remember your dreams?</li> </ul>  | <p style="text-align: center;"><u>Lifestyle</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Smoker</li> <li><input type="checkbox"/> Coffee ____/ day</li> <li><input type="checkbox"/> Tea ____/day</li> <li><input type="checkbox"/> Water ____/day</li> <li><input type="checkbox"/> Alcohol ____/week</li> <li><input type="checkbox"/> Recreational drugs</li> <li><input type="checkbox"/> Exercise ___ / week</li> <li><input type="checkbox"/> Excessive plane travel</li> <li><input type="checkbox"/>_High stress levels</li> </ul>  |

## Health Questionnaire

### 3 Day Food Diary

Write down everything you eat and drink. Include the amount of the food and list brand names of foods you bought. List exact ingredients of homemade foods and whether the food is packaged or takeaway. The purpose of this diary is not to judge your eating habits, but to learn more about your nutritional needs and strengths.

| Day1          | Day 2         | Day 3         |
|---------------|---------------|---------------|
| Breakfast     | Breakfast     | Breakfast     |
| Morning snack | Morning snack | Morning snack |
| Lunch         | Lunch         | Lunch         |
| Afternoon tea | Afternoon tea | Afternoon tea |
| Dinner        | Dinner        | Dinner        |