

Please help us provide you with a complete evaluation by taking the time to fill out carefully this questionnaire. All of your answers will be held absolutely confidential. If you have questions, do not hesitate to ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in Comments sections. Thank you.

MEDICAL HISTORY: (Check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, include approximate date or year.			
ILLNESS	DATE (YEAR)	ILLNESS	DATE (YEAR)
Abdominal Aortic Aneurysm		Bladder Cancer	
Anaemia		Breast Cancer	
Alzheimer 's disease		Cardiac Arrhythmia	
Angina		Cerebrovascular Accident (Stroke)	
Anxiety		Cervical Cancer	
Asthma/Bronchitis		Cholelithiasis	
Colon Cancer		Depression	
Coronary Artery		Diabetes	
Cystocele/Rectocele		Diverticulosis/Diverticulitis	
Deep Venous Thrombosis		Emphysema	
Heart Attack		Erectile Dysfunction (ED)	
Heart Failure		High Blood Pressure	
Heart Murmur		HIV/AIDS	
Hepatitis C		Irritable bowel syndrome	
Hiatal Hernia		Genital Condyloma	
Genital Herpes		Kidney Cancer	
Glandular Fever		Kidney Stones	
Glaucoma		Lung Cancer	
Gout		Leukemia	
Hepatitis		Padget's Disease	
Hodgkin 's disease		Parkinson's Disease	
Malignant Lymphoma		Penile Cancer	
Mitral Valve Prolapse		Polycystic syndrome	
Multiple Sclerosis		Sickle Cell anaemia	
Osteoarthritis		Testis Cancer	
Ovarian Cancer		Thalassaemia minor/major	
Prostate Cancer		Ulcerative Colitis	
Prostate Enlargement (BPH)		Urinary Incontinence	
Prostatitis		Transient Ischemic Attack (TIA)	
Pulmonary Tuberculosis		Urinary Tract Infection	
Seizures		Uterine cancer	
Thyroid Disease		Other	
Which of the following symptoms (please tick) have you had in the last 6 months?			
Symptoms			
GEN			
Anorexia	Bleed or bruise easily	Poor balance	Strong thirst (cold or hot drinks)
Cravings	Change in appetite	Sweat easily	Weight loss
Chills	Fatigue	Sweats (spontaneous)	Night Sweats
Fever	Poor appetite	Malaise	Sudden energy drop (time of day)

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Localised weakness	tremors	Any other unusual or abnormal condition you have noticed in your general sense of health ?			
Genitourinary					
Difficulty Voiding	Blood in Urine	Urinary Incontinence	Decrease in urination		
Sexual dysfunction	Painful Urination	Sores on genitals	Unable to hold urine		
Do you wake at night to urinate? how often?	Any particular colour to your urine?	How many times a day do you urinate?	Does your urine have a particular smell/odour?		
Which of the following symptoms (please tick) have you had in the last 6 months?					
GIT					
Nausea	Constipation	Flatulence/gas	Bad breath	Blood in stools	
Vomiting	indigestion	belching	diarrhoea	haemorrhoids	
Rectal pain	Black stools	Chronic laxative use	Abdominal pain or cramps	Other:	
Reproductive & gynaecologic					
Number of pregnancies	Number of births	Premature births	miscarriages	Clots with menses?	
Length of time between menses	Age of first menses	PMT/ PMS	Irregular periods	Painful periods	
Vaginal sores	Breast lumps	Menopause (age)	Describe menses (light/heavy/scanty flow)		
Change in body/psyche prior to menstruation	Do you use HRT/contractive pill? if yes what type and how long have you been using this drug?			Other:	
Muscular skeletal Symptoms					
Hand/wrist pain	Neck pain	Shoulder pains	Muscle pains	Knee pain	
Hip pain	Foot/ankle pain	Back pain	Joint Swelling	Muscle Weakness	
Other bone or joint problems?					
neuropsychological					
seizures	dizziness	Loss of balance	Poor memory	depression	
Lack of co-ordination	anxiety	concussion	Easily susceptible to stress		
Areas of numbness	Bad temper	Hallucinations	Have you ever contemplated or attempted suicide?		
Any other neurological or psychological problems?					
Cardiovascular					
fainting	dizziness	Blood clots	Irregular heartbeat	High blood pressure	
Peripheral Edema	Low blood pressure	Palpitations	Shortness of breath	Difficulty in breathing	
Chest pain	Swelling of hands	Any other heart or blood vessel problems?			
respiratory					
cough	bronchitis	Coughing blood	Asthma	wheezing	Hay fever
Pain with a deep breath		Shortness of Breath	pneumonia	Difficulty in breathing when lying down?	
Production of phlegm? if yes what colour?			Other:		

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Eyes					
Blurred Vision	Double Vision	Eye Pain	Eye Discharge	Eye Irritation	Vision Loss
Other:					
Ears, Nose, and Throat					
Ringing in Ears	Decreased Hearing	Hoarseness	Ear Pain	Rash	Itching
Pain with Swallowing	Nose Bleeds	Other:			
Skin					
Suspicious Lesion	psoriasis	Acne	Dryness	eczema	itching
Other:					
Endocrine					
Heat Intolerance	Weight Change	Cold Intolerance	Increased Thirst	Loss of hair	Increased hair growth
Change in hair texture	Acne	Other:			
Haematological and Lymphatic					
Abnormal Bruising	Easy Bleeding	Enlarged Lymph Nodes			
Other:					
Allergic and Immunologic					
Hay Fever	HIV Exposure	Itching			
Other:					

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Yr.

ALLERGIES

Please list all drug/food allergies including type of reaction.

drug/food allergies	type of reaction

Physical Activity please tick which of the following you partake in

Inactive	Walking	Running	Swimming	Aerobic Training
Strength Training	Recreational Activities	Other		

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Which of the following best describes your daily diet?

Regular	Diabetic	Weight Reduction	Low Fat	Renal Failure
Weight Gain	Vegetarian	Gluten Free	Lactose Free	Vegan
Other:				

Which of the following do/did you partake in?

Activity	Beer (drinks/ wk)	Wine (drinks/wk):	Liquor (drinks/wk):	Cigar (#/day):	Cigarette (pks/day):	Cocaine (#/day):	Marijuana (#/day):	Other
Duration years								
Date Discontinued								

FAMILY HEALTH HISTORY

If there is a history of familial disease please tick **OR** IF THERE IS FAMILIAL DISEASE PLEASE CIRCLE THOSE RELEVANT AND INDICATE RELATIVE

Relative (i.e., Father, Mother, Uncle, Sister, etc.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cardiovascular disease | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Asthma |

Please describe your average diet: (breakfast, lunch, dinner, snacks, drinks etc)

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Have you ever been on a restricted diet?.....What kind?.....

Birth history (prolonged labour, forceps delivery etc):.....

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Please check if you had had in the last three months;

General:

- Poor appetite Poor sleeping Poor balance Localized weakness
- Sudden energy drop (time of day.....) Strong thirst (preference for cold or hot drinks)
- Weight loss Fever Night sweats sweat easily
- Bleed or bruise easily change in appetite Tremors Weight gain
- Chills Cravings

Any other unusual or abnormal conditions you have noticed in your general sense of health?.....

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Other relevant medical history:.....

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COMMENTS:.....

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CERTIFICATION

The above information is true to the best of my knowledge.

Signed..... Date of Signature.....

Patient/Legal Guardian/Authorized Person (Signature).....

Thank you for taking the time to fill in this form, which will greatly assist us to help you. Please bring this form to your first appointment.