DATE:_____

PATIENT PROFILE

SURNAME:_____ **GIVEN NAMES:**_____

ADDRESS:_____

_____POSTCODE:_____

TELEPHONE (Home):_____ (Work):_____(Mob):_____

EMAIL:_____ OCCUPATION:_____

DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS:_____

MEDICARE NUMBER:_____ EXPIRY DATE:_____ REF:_____

HEALTH INSURANCE FUND:_____MEMBERSHIP NO:_____

VETERANS AFFAIRS NO:_____ PENSIONER: ☐ YES ☐ NO

CONTACT INFORMATION

NEXT OF KIN

Name:_____Relationship:_____

Address:_____

_____

Telephone (Home):_____(Work/Mob):_____

ADDITIONAL CONTACT

Name:_____Relationship:_____

Address:_____

_____

Telephone (Home):_____(Work/Mob):_____

GP INFORMATION

LOCAL DOCTOR:_____TELEPHONE:_____

ADDRESS:_____

_

SPECIALIST PHYSICIAN/SURGEON:_____TELEPHONE:_____

LIFESTYLE INFORMATION

ALCOHOL INTAKE *(standard drinks per week)*:_____ **CHOICE OF ALCOHOLIC DRINK:** _____

CIGARRETES

☐ SMOKER (_____/Day) ☐ EX-SMOKER (How Many Years:_____Stopped:_____) ☐ NEVER SMOKED

CURRENT DEDICATED EXERCISE

0 Days/Week	1-2 Days/Week	2-4 Days/Week	4-7 Days/Week			***(circle one)***
Walking/Running	Cycling	Swimming	Yoga/Pilates	Gym/Trainer	Other	***(circle one)***

SLEEP PATTERNS

a)	**I consider my sleep is:**	Good	Fair	Poor	***(circle one)***
b)	**I usually sleep:**	6-8 hrs	4-6 hrs	>4 hrs	***(circle one)***
c)	**I have sleep problems:**	Yes	No	Sometimes	***(circle one)***

SURGICAL HISTORY

PLEASE GIVE DETAILS OF PAST OPERATIONS:

1. _____

2. _____

3. _____

4. _____

5. _____

WOMEN'S HEALTH

A. Do you have regular periods (26-33 days)? Yes No

If no, please provide further details_____

B. Do you have problems with heavy periods? Yes No

If yes, please provide further details_____

C. Have you had difficulty conceiving in the past? Yes No

D. Do you currently have problems with infertility? Yes No

E. Have you suffered from excess body hair or acne? Yes No

F. Have you been diagnosed with polycystic ovaries? Yes No

MEDICATIONS

Please provide details-name and length of use-of any medication you are currently on, or have previously been on, for any of the following: psychiatric disorders, migraines, weight loss, epilepsy, asthma or breathing, or hormones (e.g. Pill, HRT, Cortizone).

CURRENTLY: _____

_____

PREVIOUSLY: _____

_____

_____

GASTRO-OESOPHAGEAL REFLUX/INDIGESTION

1. Do you have a history of heartburn or indigestion? Yes No ***(circle one)***
2. How often do you experience reflux (e.g., daily, most days, occasionally)? _____
3. How often do you experience indigestion/heartburn during the night? _____
4. What causes/aggravates your reflux? _____
5. What treatments do you use to relieve your reflux, heartburn, or indigestion? _____
6. Do you have difficulty swallowing? Yes No ***(circle one)***
7. Does food ever get stuck when you swallow? Yes No
8. Does food or fluid reflux back into your mouth? Yes No
9. Do you vomit when you experience reflux? Yes No
10. Do you suffer from recurrent sore throats? Yes No
11. Do you suffer from a hoarse voice? Yes No
12. Do you suffer from a regular evening cough? Yes No

If you answered yes to any of the above, please provide details: _____

_____

_____

_____

MEDICAL ASSESSMENT

WEIGHT:_____KG HEIGHT:_____CM BMI:_____ NECK:_____CM

WAIST:_____CM HIP:_____CM BLOOD PRESSURE:_____/_____MM/HG

HIGHEST ADULT WEIGHT:_____KG LOWEST ADULT WEIGHT:_____KG IDEAL WEIGHT:_____KG

MEDICAL HISTORY

Have you suffered with any of the following? ***(Please circle one and provide relevant details below)***

1.	**DIABETES** *NB*	Yes	No
2.	Diabetes whilst pregnant	Yes	No
3.	Asthma	Yes	No
4.	Respiratory/breathing problems	Yes	No
5.	Arthritis or joint pain	Yes	No
6.	Back pain	Yes	No
7.	Kidney or urinary disorder	Yes	No
8.	Neurological problems	Yes	No
9.	Psychological disorders	Yes	No
10.	Gallstones	Yes	No
11.	Gastric/duodenal ulcer	Yes	No
12.	Hepatitis or liver disease	Yes	No
13.	High blood pressure	Yes	No
14.	Heart disease	Yes	No
15.	High cholesterol	Yes	No
16.	Anaemia/bleeding disorder	Yes	No

17. Thrombosis/clotting disorder Yes No

18. Varicose veins or leg swelling Yes No

19. Eczema or skin condition Yes No

20. Hay fever or rhinitis Yes No

21. ALLERGIES *NB* ***(incl. food, medications, dressings)*** Yes No

Please list all allergies:_____

_____

_____

Please provide details regarding any of the above or any other illnesses or problems not listed:

_____

_____

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