PRIVATE & CONFIDENTIAL HEALTH REVIEW

Please complete this Questionnaire and bring it to your 1st appointment.

	Healthy Heights Clinic 71 New Street West, Balgowlah Heights 2093 0299486600 email: healthyheights2093@gmail.com

Surname	Given Names	Date of Birth

How many children

Address	Telephone
Mobile	**Email**
Marital Status M/S/W/D	**Male/Female**
Children	**GP**
Current Occupation	**Previous Employment**
Stress level with work LOW/MED/HIGH	**Do you work with chemicals**
Pets (What sort)	**Allergies**
Alcohol Intake	**Recreational Drug**
Exercise	**Tick Bites? If so when and is there mark or rash**

List all current medication and supplements being taken

Supplement/Meds	Dosage	X daily	Duration

Presenting Condition, please describe your reason for this consultation and the outcomes you would like to achieve

Blood Pressure	Live Blood Analysis	Iridology

Nails	Tongue	Skin
Hair	**Feet**	**Toe**

Blood Pathology Results	Functional Test Results
Gene Testing	

FAMILY HISTORY

Please note if either you or any of your family have ever suffered from any significant medical problem. If possible, note the age of onset of cardiac events and type of cancer, arthritis or allergy. Otherwise simply tick.

	Self	Father	Pat Grand father	Pat Grand mother	Father's Siblings	Mother	Mat Grand father	Mat Grand mother	Mother's Siblings	Siblings	Your Child
Alcoholism											
Allergies											
Anxiety											
Asthma											
Arthritis											
Bowel Disease											
Cancer											
Dementia											
Depression											
Diabetes											
Epilepsy											
Gall Stones											
Heart Attack											
Hypertension											
Osteoporosis											
Parkinson's											
Schizophrenia											
Stroke/TIA											
Thyroid disease											
Other											

PAST MEDICAL HISTORY

Asthma or Bronchitis		**Colic**		**UTI**	
Recurrent middle ear		**Constipation**		**Ulcers**	
Convulsions		**Diarrhoea**		**Cold Sores**	
Recurrent tonsillitis		**Thrush**		**Hyperactivity**	

Pneumonia		**Angina**		**Fainting/Vertigo**	

Pleurisy		**Meningitis**		**Nervous exhaustion**	
Encephalitis		**Glandular Fever**		**Hepatitis**	

Have you been partially (P) or fully (F) immunised against these infections?

Whooping cough / Pertussis		**Haemophyilus B**	
Diphtheria		**Hepatitis A (last booster date)**	
Polio		**Hepatitis B (last booster date)**	
Tetanus (last booster date)		**Flu/influenza (how many years?)**	
Measles		**Pneumonia**	
Mumps		**Other**	
Rubella/German Measles			

Please list all surgery, fractures, major trauma and car accidents:

DATE	**EVENT**

GENERALISED SYMPTOMS

1.	**I suffer with severe fatigue**	
2.	**I suffer with fatigue which makes me feel weak and drained**	
3.	**My fatigue makes me feel sleepy tired, I can sleep given the chance**	
4.	**When fatigued I cannot think or concentrate or remember words**	
5.	**If I do any exercise I initially feel invigorated by it**	
6.	**If I do any exercise, I later feel much more fatigued and drained**	
7.	**I awake feeling extremely fatigued and pick up a bit later in the day**	
8.	**I become very fatigued in the mid afternoon**	
9.	**I seem to get a second wind of energy in the evening**	
10.	**I have been unable to attend work or studies due to fatigue**	
11.	**I characteristically get fatigued about 2-4 hours without eating**	
12.	**I have observed that if I eat certain foods I become very fatigued. Please list:**	
13.	**When did you 1st develop significant fatigue?** **Comments?**	

14.	**Do you react very strongly to any chemicals? Yes / No**	
15.	**How do you react?**	

IMMUNE AND RESPIRATORY SYSTEMS

16.	**Do you suffer frequent colds or flu eg; 2-4 a year = often, 5-10 a year = usually**	
17.	**If so, do you become extremely fatigued when suffering a cold or flU?**	
18.	**Do you recover slowly, ie. several weeks**	
19.	**Do you suffer frequent sore throats**	
20.	**Do you suffer frequent sore or swollen gland in the neck**	
21.	**Do you suffer frequent swollen glands in the armpit or groin**	
22.	**Do you get any recurrent fevers or sweats? (including at night)**	
23.	**Have you had many antibiotics? (for any reason)**	
24.	**Do you have a reaction to any antibiotics**	
25.	**Do you get hayfever?**	
26.	**If yes, is it only in spring? Yes / No or anytime of the year? Yes / No**	
27.	**Have you had any scratch tests? If yes, when?**	
28.	**Are you often blocked up in the nose?**	
29.	**Do you get bouts of sinusitis?**	
30.	**Do you have a lot of mucous in the nose and throat?**	
31.	**Do your eyes get very itchy?**	
32.	**Do you snore?**	
33.	**If yes, do you ever wake yourself up with the noise or feeling of choking?**	
34.	**Do you wake up in the morning with a very dry mouth?**	
35.	**Do you get cold sores? (eg; 2-4 a year = often, 5-10 a year = usually)**	
36.	**Do you get mouth ulcers without biting yourself accidently?**	
37.	**If yes, do they heal slowly, eg; more than 1 week**	
38.	**Do you get a bad taste in your mouth, eg; metallic or bitter?**	
39.	**Do you have bad breath?**	

40.	**Do the corners of your mouth ever become fissured, inflamed?**	
41.	**Do you get middle ear infections?**	
42.	**Do you suffer from ringing in the ears?**	
43.	**Do you ever experience episodes of loss of balance?**	
44.	**Do you ever suffer with asthma?**	
45.	**If yes, is it provoked by (please circle) exercise, cold air, getting a cold or flu, exposure to dust, cats, grasses?**	
46.	**Have you ever attended Casualty or been hospitalised with asthma? Yes / No**	
47.	**How long will a Ventolin puffer last?**	
48.	**Do you wake overnight with tightness and wheezing needing Ventolin?**	
49.	**Have you ever been diagnosed as having bronchitis?**	
50.	**Do you ever get a wheeze, eg; with exercise, whether diagnosed as asthma or not?**	

CARDIOVASCULAR SYSTEM

51.	**Do you ever get chest pains / angina Yes / No**	
52.	**Without exercise, do you ever feel short of breath, starved of air?**	
53.	**Is this shortness of breath associated with pins and needles sensations anywhere?**	
54.	**Do you ever get palpitations, feelings of skipped irregular heartbeat?**	
55.	**Do you ever get skipped irregular heartbeats?**	
56.	**Are you aware of unprovoked strong pounding heartbeats?**	
57.	**Do you have high blood pressure?**	
58.	**Do you ever find walking causes a cramping ache in your legs or calves?**	
59.	**If yes, how many metres does it take to provoke this?**	
60.	**Do your hands or feet get very cold easily?**	
61.	**If yes, do they turn blue or white? Yes / No**	

GASTROINTESTINAL SYSTEM

62.	**Do you ever suffer from heartburn or reflux?**	
63.	**Do you ever suffer from pain in the upper stomach region?** **Which treatment method is used?**	
64.	**Do you suffer from nausea/feeing sick?**	

65.	**Do you have a poor appetite?**	
66.	**Do you experience a bitter or metallic taste?**	
67.	**Do you sometimes get abdominal bloating?**	
68.	**Do you suffer from crampy, colicky abdominal pain?**	
69.	**Do you pass a lot of wind?**	
70.	**If yes, does it usually smell offensive?**	
71.	**Are your bowel habits usually regular?**	
72	**How often do you usually open your bowels?**	
73.	**Do you use laxatives?** **If yes, which and how often?**	
74.	**Do you ever suffer from diarrhoea?**	
75.	**If yes, do the motions smell offensive?** **Does the stool colour tend to be (please circle) pale straw, very dark, bright mustard yellow, other**	
76.	**Do you ever observe blood in your bowel motions?**	
77.	**Do you ever observe mucous in your bowel motions?**	
78.	**Do you suffer with haemorrhoids?**	
79.	**Do you tend to get itchy around the anal area?**	
80.	**Are there any foods which cause you definite symptoms? Please specify which foods and which reactions:** **FOOD REACTION**	

GENITOURINARY SYSTEM

81.	**Have you ever had any urinary tract infections?**	
82.	**Do you need to get up at night to urinate?**	
83.	**If yes, how many times per night on average?**	
84.	**Do you have satisfactory levels of libido?**	
85.	**Are you currently sexually active?**	
86.	**How many sexual partners have you had in your lifetime?**	
87.	**Do you feel any pain during intercourse?**	
88.	**Have you ever had any STD's?**	

	For Men Only	
89.	**Do you have a problem initiating urination?**	
90.	**Is the strength of the flow of urine diminished?**	
91.	**Do you tend to dribble at the end of urination?**	
92.	**Do you ever develop irritation of the skin of the penis?**	
93.	**Do you have problems maintaining an erection?**	
	For Women Only	
94.	**Are you currently on the contraceptive pill? Yes / No** **If yes which one?**	
95.	**Have you ever had problems with the contraceptive pill? Yes / No**	
96.	**Are your periods regular? Yes / No**	
97.	**How many days in your cycle?**	
98.	**Are your period's heavy?**	
99.	**Do you become very tired during your period?**	
100.	**Are your periods painful?**	
101.	**During the week before your period, do you experience (please circle) Irritability, anxiety, depression, tearfulness, painful and or swollen breasts, swollen ankles, puffy fingers, cravings, for chocolate or other sweets**	
102.	**Do you take any supplements to help PMS? Yes / No. If yes please specify:**	
103.	**Do you ever suffer from vaginal thrush?**	
104.	**Do you experience pain during intercourse?**	
105.	**Have you ever had an abnormal PAP smear?**	
106.	**Do you ever lose bladder control if straining, coughing, laughing etc?**	
107.	**When 1st being aware of the need to urinate, must you urinate urgently?**	
108.	**How many times have you been pregnant?**	
109.	**How many births have you had?**	
110.	**Have you ever had a pregnancy termination? Yes /No**	
111.	**Have you ever had any problems with pregnancy? (please describe)**	
112.	**Have you ever had any problems with delivery? (please describe)**	

MUSCULOSKELETAL SYSTEM

113.	**Do you get a lot of muscle aches and pains Yes / No. If yes , any particular muscles?**	
114.	**Do you get occasional muscle cramps?**	
115.	**Do you ever get any muscle twitches? Eg; around the eye**	
116.	**Do you get sore joints? Eg; fingers or knees**	
117.	**Do you ever wake up in the morning very stiff and sore?**	
118.	**Do you tend to get neck pain?**	
119.	**Do you tend to get back pain?**	
120.	**Do you get sciatica?**	
121.	**Do you visit a chiropractor or osteopath?**	
122.	**Do you take anti inflammatory / anti-arthritis medications? If yes which ones?**	
123.	**Do your hands go red, white or blue in the cold?**	
124.	**Do you ever get chill blains?**	

NERVOUS SYSTEM

125.	**Have you ever fainted? Yes / No**	
126.	**Do you occasionally feel faint and lightheaded?**	
127.	**Do you ever experience a spinning, off balance, drunk like feeling?**	
128.	**Do you get ringing in the ears?**	
129.	**Do you suffer episodes of blurred or double vision?**	
130.	**Do you notice any loss of taste or smell?**	
131.	**Are you hypersensitive to smells?**	
132.	**If yes, any especially?**	
133.	**Do you suffer from headaches? If yes, is it usually (please tick)** **Across the forehead, behind one eye, in a band around the head, in the temples, at the back of the head**	
134.	**Do you suffer from migraines?**	
135.	**If yes, do you get an aura, eg; visual effects, before the actual headache?**	
136.	**Do you also suffer nausea and or vomiting during a migraine?**	
137.	**What medication do you currently take to prevent or treat migraines?**	
138.	**What medications have you tried unsuccessfully in the past, to treat migraines?**	
139.	**Do you ever experience numbness or tingling anywhere? Yes / No. If yes, please specify where**	

140.	**Do you ever experience fleeting shooting or stabbing feelings?**	
141.	**Do you have weakness of any particular muscle? Yes / No. If yes, specify which**	
142.	**Do you have problems with short term memory recall?**	
143.	**Do you have problems with long term memory recall?**	

Nervous System

144.	**Is your work generally enjoyable?**	
145.	**Do you have to work long hours?**	
146.	**If yes, up to how many hours per day? per week?**	
147.	**Is your work very stressful in any way? If yes, please comment:**	
148.	**Is your home life generally happy and supportive?**	
149.	**Do you have a good support network of friends?**	
150.	**Do you have a good support network of family?**	
151.	**Do you have any significant current relationship stresses?**	
152.	**Do you consider yourself to have had a happy childhood? If not please comment:**	
153.	**Have you ever suffered significant loss, grief, eg; death of family or friend? If yes, please comment;**	
154.	**Do you generally feel positive about yourself?**	
155.	**Do you feel you have a reasonable degree of control over your life?**	
156.	**Are you currently generally happy with your life?**	
157.	**Are you generally an easy going person?**	
158.	**Do you tend to be a worrier?**	
159.	**Have you ever been suicidal? Yes / No**	
160.	**Are you able to confide your feeling to others?**	
161.	**Do you feel well motivated?**	
162.	**Do you feel negative, hopeless and depressed? If yes, please comment:**	
163.	**Do you have significant financial hardships or stresses? If yes, please comment:**	
164.	**Do you generally get off to sleep easily?**	
165.	**What time do you generally get to sleep?**	
166.	**Do you wake overnight?**	
167.	**If yes, how many times usually?**	

168.	**How long does it take you to get back to sleep?**	
169.	**Do you remember your dreams easily? Yes / no**	
170.	**If yes, do you tend to have many nightmares? Yes / No**	
171.	**Do you wake in the morning well rested?**	
172.	**Do you ever have daytime sleeps? Yes / No** **If yes, how often?**	

DIET

173.	**Do you ever crave any foods? Yes / No. If yes, which ones?**	
174.	**Have you ever tended to binge eat any foods? Yes / No. If yes which ones?**	
175.	**Have you ever purged or forced vomiting after eating? Yes / No**	
176.	**Do you tend to skip any meals? Yes / No. If yes which ones?** **How many times per week do you skip these meals?**	

What do you usually have for these meals? (Specify cereals, toast toppings, sandwich content, etc. More than one answer is ok.

BREAKFAST	
MORNING TEA	
BEVERAGES	
LUNCH	
AFTERNOON TEA	
DINNER	
SUPPER	

Coffee + sugar + milk	
Tea + sugar + milk	
Chocolates	
Lollies	
Soft drinks (specify)	
Fruit juice (specify)	
Water	
Cordial	

Chips	
Bread	
Milk	
Cheese	
Yoghurt	
Ice cream	
Fruit	
Dried fruits	
Nuts	
Red meat	
Chicken / pork	
Fish	
Fresh vegetables (specify most common)	
Rice	
Pasta	
Potatoes	
Salt	
Pepper	
Hot spicy foods	
Take aways (specify)	
Alcohol	
Other	

MEDICATIONS AND SUPPLEMENTS

List all known allergies or intolerances, the reaction, and if ever tested, how?

MEDICATION/SUPPLEMENT	REACTION

Any comments you wish to add regarding your health:

Thank you very much for your time and assistance in filling out this questionnaire.