Follow Up Questionnaire (Please do and submit electronically by email)

Date

Name

Best Contact Number and Email

**This Questionnaire is to be completed prior to your appointment and will facilitate a more cost effective use of your and Dr Read’s time. As you pay pro rata for consultation time this limits wasting time with translation of information into the medical record and through typing. This means your consultation can focus on filling in the gaps, understanding the subtle complexities of your case, creating a treatment plan and with explanations. Detail and accuracy will facilitate better diagnosis and planning.**

**PLEASE PUT INFORMATION IN POINT FORM WHERE POSSIBLE AND DO NOT WRITE IN BOLD AS THIS ALLOWS FOR EASY REFERENCING LATER. DO NOT WRITE in the first person using I MY MINE etc as these will need to be removed manually.**

Major Issues For This Consultation:

A. Ongoing Issues and Progress

1.

2.

3.

4.

Improvements:

New Issues

Current Treatment Plan

Including Dose , Ingredients Benefits Side Effects and Duration of Use

Drugs:

Supplements:

Current Diet and Food Reactions:

Current Physical Activity:

Current Mood Emotional Wellbeing and Stressors:

Current Sleep:

Limitations of Usual Activity/ Disbaility:

Symptom Review

Systemic Symptoms (Weight Change/ Sweats/ Fever):

Exercise Tolerance, (Fatigue and Post Exertional Fatigue Issues):

Gastrointestinal Gut Symptoms:

Neurological ( Nerve/ Head Symptoms Dizziness Balance and Brain Fog):

Visual Issues:

Musculoskeletal Symptoms and Pain:

Heart Lung Chest Symptoms:

Ear Nose and Throat and mouth Symptoms:

Skin Hair Nail Issues:

Hormonal Sexual Health Issues and Gynaecological Symptoms:

Urinary Symptoms:

Tests /Unchecked Results for Review

New Scripts Needed in Next 2 months

Reports Certificates Needed

Other

**Are you happy for your information to be used anonymously in research?**