**NEW PATIENT QUESTIONNAIRE ( Please complete and submit electronically)**

**Please bring previous reports letters and results or call ahead to arrange download**

Date

Name

Best Contact Number and Email

Medicare Number

Address

**This Questionnaire is to be completed prior to your appointment and will facilitate a more cost effective use of your and Dr Reads 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 so is important.**

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

**Main Issues**

1.

2.

3.

4.

5.

**History/ Background of Main Issues above**

**(Onset of illness and details, Duration, treatments investigations etc)**

1.

2.

3.

4.

5.

**Medical Diagnoses and Past Medical History Including Birth/Child Health/ Breast Feeding**

1.

2.

3.

4.

5.

**Current Medications dose and frequency**

:

**Current Supplements with specific ingredients and amounts**

:

**Previous beneficial Treatments/ Therapies tried**

:

**Previous Unsuccessful therapies**

:

**Lifestyle Factors**

**Current Diet (typical meals details and frequencies)**

Breakfast

Morning Tea

Lunch

Afternoon Tea

Dinner

Dessert

Snacks

Drinks

Cravings

**Previous Diets tried and effect**:

**Food Intolerances and Reactions** :

**Physical Activity and Exercise**:

**Sleep/ Hours/ Quality /Snoring**:

**Allergies and Medication side effects** :

**Non drug allergies** :

**Social History**

**Relationship status and living situation** :

**Children** :

**Alcohol consumption amount and frequency** :

**Smoking Status Now and previous** :

**Recreational Drug Use history** :

**Emotional Stressors** :

**Environmental History**

**Current Occupation and Previous Occupations** :

**Occupational and Other chemical Exposures** :

**Chemical Sensitivities** :

**Electromagnetic / EMF Sensitivities**:

**Travel History and related Illnesses** :

**Home exposures Including Mould and home renovations**:

**Insect and Tick Bites and Reactions** :

**Exposure to farm Animals or other animals birds rodents etc**:

**Environmental Associations / exacerbation of illness**:

**Current Symptom Review**

**Cardiac Heart symptoms** :

**Breathing Respiratory Symptoms** :

**Gastrointestinal/ Abdominal Symptoms** :

**Urinary Symptoms** :

**Ear Nose and Throat Symptoms**:

**Neurological Symptoms** :

**Visual/ Eye Symptoms**:

**Psychological and mood Symptoms** :

**Musculoskeletal Symptoms**:

**Skin Hair Nail Issues** :

**Weight Changes and Appetite** :

**Systemic symptoms fatigue fever sweats** :

**Musculoskeletal and Joint symptoms** :

**Previous Pregnancy history** :

**Gynaecological Symptoms** :

**Menstrual and Premenstrual related symptoms** :

**Functional Disabilities and Issues with daily activities**:

**Family History of Illness**

**Previous Doctors Seen and Outcome**

**Vaccination History and Reactions**:

**Summary of Previous Pathology and Radiology results (Abnormal or significant normal tests)**

**Main Goals**

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