FAMILY DOCTOR ST IVES - PATIENT QUESTIONNAIRE

Title:		**Date of birth:**
Name:		
Address:		
E-mail:		
Home Phone number:		**Mobile Phone number:**
Emergency contact details:	**Contact Name:**	**Contact Phone number:**
Medicare number:	❑❑❑❑ ❑❑❑❑❑ ❑ Patient reference number: ❑ Expiry date:	
Current weight:		**Desired weight:**

Do you exercise regularly?

YES / NO - What is your regimen?

Medications:

Allergies:

Vitamins, mineral, herbal, homeopathic supplements:

Do you suffer from any of the following?

- ❑ Diabetes
- ❑ Liver disease
- ❑ Heart disease
- ❑ Fluid retention
- ❑ Urinary infections
- ❑ Kidney disease
- ❑ High blood pressure
- ❑ Epilepsy
- ❑ Digestive problems
- ❑ Recurrent infections
- ❑ Auto-immune disease
- ❑ Other: _____

Previous operations:

Main reasons for today's visit:

Diet – thinking about the last 3 days, what did you typically eat:

Breakfast:	Lunch:	Dinner:

How much alcohol do you drink?

How many soft drinks do you consume?

How much water?

Do you use artificial sweeteners?

YES / NO - Which ones:

Do you smoke?

YES / NO - How many per day?

Do you sleep well?

Anything else you would like to note?

How did you hear about us?