V1

IBS History Record

KARUNA HEALTH CARE
Jon Gamble BA ND Adv Dip Hom jon@karunahealthcare.com.au
Nyema Hermiston RN ND Adv Dip Hom nyema@karunahealthcare.com.au

Allow 20 minutes to complete this form

Date.....

Name.....Age.....Sex.....DOB.....

Address.....Post Code.....

Phone: **H:**.....**W:** .....**Mob**.....

Email.....Health Fund.....

Occupation.....Marital Status:.....Children.....

Health Fund.....

GP's name, address and contact number: .....

Your specialist's name, address and contact number: .....

* For distance consultations, please indicate how we are able to contact you:
□ Email □ Telephone □ Fax (.....)..... □ Skype user name.....

What would you like to have treated? (Include your medical diagnosis)

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What are your symptoms? Describe in your own (not your doctor's) words. Also note the specific questions below.

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How long have you had this condition for?.....

When did it start? (Eg following a virus or after taking a medication; change of living premises; change of diet; a particular stressful event, etc)

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Please describe *how* your symptoms started (if different from above)

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What medical treatment(s) have you had so far?

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Please list all your **current** prescribed medications

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What natural therapies have you used so far?

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Please list your current supplements – vitamins, minerals etc

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Which of these treatments have you found to be the most effective?

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What makes your symptoms feel better? (Time of day; heat or cold; climate; food; body position; activity etc)

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What makes your symptoms feel worse?

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Do you have any other health problems? If yes, please list (also note specific questions below):

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1. <u>Digestion:</u>

Do you have: □ Pain □ Bloating □ Indigestion □ Burping □ Diarrhoea □ Constipation □ Wind
□Gastric reflux □Peptic ulcer □Nausea □Heartburn

When do you get these symptoms in relation to eating? Please state - between meals, before, during or afterwards?

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……

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How often?……..

How severe? ……
.
When do you get the most hungry? ……

What are your favourite foods? ……

Which foods do you really dislike? ……..

How thirsty do you get? ……..…..…….……..
..
What do you like to drink? ……. How much? ……..

How much alcohol do you drink? ……What type? ……..

<u>2. Bowels:</u>
Stool consistency (mushy, watery, hard etc)…….

Stool colour (chocolate, clay, green, mucous, bloody etc)…….

How often on average do you have a bowel motion?…….

How much per day (two “doughnuts”, one “bagel”, one 1 cm “thin sausage” 6 cm long, etc)…….

What are your trigger foods; which food causes or makes your tummy symptoms worse?.....

……..

Does your IBS wake you up from sleep? ……..

If you have abdominal pain, – which part of the abdomen in particular (eg “2 cm below navel with a diameter of 4 cm”)…….

……

Describe the pain……..

Excessive flatulence? smelly / non-smelly……..

Diarrhoea alternating with constipation……

Food intolerance or allergy symptoms after eating trigger foods: eg skin rash, headache, mental fog, mood disturbance, etc….

……

Other:

3. Please mention any other symptoms that you ***currently have:*** (Use back of page if needed)

Head heat; pain; perspiration; dizziness.....

Eyes vision disturbance; soreness; dark circles; conjunctivitis.....

Ears discharges; itchiness; noises.....

Nose blockage; discharge; snoring; catch colds easily, hay fever.....

Teeth swollen gums; bleeding; teeth grinding; decay.....

Any amalgams? (silver fillings) .....At what age did you first have amalgams? .....

Skin rashes, itchiness red, dry, oily, insect reactions.....

Muscles/joints arthritis, pain, inflammation, stiffness….....

Bladder cystitis, frequency, bleeding, pain .....

Please rate your energy levels (circle) [No energy] **0 1 2 3 4 5 6 7 8 9 10** [high energy]

Symptoms during sleep? eg restlessness, sleepwalking, night sweats, disturbing dreams……

……

Are you wakeful? …… If so, at what time(s)? ……

What position do you like to sleep in? .....

How do you feel in the morning after waking?.....

4. Women: period pain, PMT menstrual cycle .....

Reproductive problems.....

5. **Men:** prostate health, frequency, fertility.....

6. Allergies:

Are you sensitive or allergic to: □ Drugs including penicillin, sulphur, vaccinations ……

□ Foods ……

□ Environmental including pollens, petrochemicals, pesticides, moulds ……

□ Sinus or hay fever ……

7. Body temperature

How do you tolerate hot weather?……Cold weather?……

Perspiration? Which body part? ..... Flushes of heat or cold? Which body part?.....

Which season do you feel: most comfortable in?.....Least comfortable? ……

How does wind affect you?.....

How does sun, cloudy weather, rainy weather or other weather affect you?.....

8. Mental/Emotional

Do you have any fears or phobias? (eg heights, spiders, tunnels, crowds, snakes, the dark, public speaking)

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What do you worry about? .....

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Is there anything about yourself, apart from your presenting complaint, which you feel impedes your ability to enjoy life and which you would like to change?

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9. Lifestyle

Do you smoke?..... If so, how many per day? ..... How many years? .....

Do you use recreational drugs? .....Which one(s) .....How often? .....

How much exercise do you do? ..... What type? .....

10. MEDICAL HISTORY

Have you had any reactions to vaccinations? ..... If so, which one(s) and at what age? .....

If you had a reaction of any kind to any vaccination, what were the symptoms?

.....

Any severe effects from any childhood illnesses?.....

Did you suffer from recurring:
□ chest infections or coughs □ ear, nose & infections □ skin problems □ stomach pains □ nose bleeds □ headaches?

Approximately how many courses of antibiotics have you taken in your life?.....

Are you aware of any affects of antibiotics on your health, particularly your digestion?.....

Have you had glandular fever or other significant virus? .....If so, at what age? .....

*Please complete this time line in detail, including **viruses, doctor visits, prescribed medication, injuries, hospitalisations and operations.***
*We need to know your health events **in the same order that they occurred.***
Include also any history of exposure to pesticides, chemicals, tic or mosquito bites and injuries.
Please also include: Restless leg syndrome, Chronic Fatigue Syndrome, Fibromyalgia, Allergies, Recurring viral infections

Use the back of this page if needed

0 - 5 yrs: .....

.....

5 -10 yrs: .....

.....

10 -20yrs .....

.....

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20-30 yrs: .....

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30-40 yrs: .....

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40-50 yrs: .....

50-60 yrs:.....

.....

60+yrs:.....

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TESTS
Please list medical tests you have had, ***in chronological order***:

TYPE OF TEST	DATE	REASON	RESULT
□ Blood test(s)			
□ X Ray(s)			
□ CT scan			
□ Ultrasound			
□ Hearing test			
□ Other			

Family History
Please describe **all known diseases** of the following family members eg heart disease; high blood pressure; diabetes; cancer; skin problems (eg psoriasis); TB; allergies; mental illness; alcoholism

Mother .....

Father .....

Immediate family (brothers, sisters, grandparents, aunts and uncles;

.....

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Anything else you would like to mention?

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Where did you hear about this clinic?
□ Word of Mouth □ Advertisement □ Brochure □ Yellow pages **book** □ Yellow Pages **online**
□ Natural Therapy Pages □ Personal Internet search □ Other .....

Please note: if you are attending the clinic:

- To help our chemically sensitive patients, please do not wear perfume, when attending the clinic.
- To find out the amount of your Health Fund rebate, please check with your fund prior to your consultation.
- Distance consultations do not usually attract rebates.

KARUNA HEALTH CARE
21 Hambridge Road Yerrinbool NSW 2575 Phone 02 4883 9639
122 Church Street Wollongong NSW 2500 Phone: 61 2 4228 0977 • Fax 61 2 4872 1261
Centre of Health Suite 5 (rear) 34 East Street Five Dock NSW 2046 Phone: 61 2 4228 0977
www.irritablebowelsyndrome.net.au