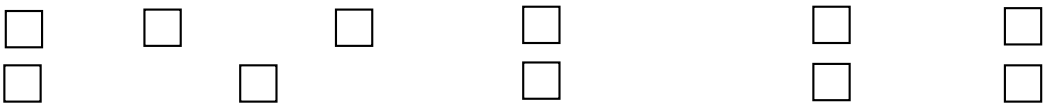

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Women

Period pain, PMT, menstral cycle

Reproductive problems

Men

Prostate health, frequency, fertility

Allergies

Are you sensitive to

- ☐ Medications: including penicillin, sulphur, vaccination
- ☐ Food
- ☐ Environmental: pollens, petrochemicals, pesticides, moulds
- ☐ Do you suffer from sinusitis or hayfever?

Body Temperature

How do you tolerate hot weather? Cold weather?

Perspiration / flushes? Which body part?

What season do you feel most comfortable?

How does wind affect you?

How does sun, cloudy weather, rainy weather affect you?

Mental/Emotional

Do you have any fears or phobias? (e.g. heights, spiders, tunnels, crowds, snacks, the dark, public speaking, thunderstorms)

If anxious, what do you worry about?

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?

Lifestyle

Do you smoke? How many a day? How many years?

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

How much exercise do you do? What type?

Medical History

Have you had any reactions to vaccinations? Which one(s)?

If you have had a reaction to any vaccination what were the symptoms ? at what age?

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Any severe effects from childhood illnesses?

Did you suffer from any recurring:

- ☐ chest infections / coughs
- ☐ ear, nose & throat 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 effects of antibiotics on your health, particularly your digestion?

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

Please complete the timeline in detail, including **viruses, doctors visits, prescribed medications, injuries, hospitalisations and operations, in the same order in which they occurred**.
Include also any history of exposure to pesticides, chemicals, tick or mosquito bites and injuries.
Please also include: restless leg syndrome, chronic fatigue syndrome, fibromyalgia, allergies, recurring viral infections.

0-5 yrs:

5-10 yrs:

10-20 yrs:

20-30 yrs:

30-40 yrs:

40-50 yrs:

50 + yrs:

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Tests

Please list medical tests you have had

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 e.g. heart disease, high blood pressure, diabetes, cancer, skin problems (e.g. psoriasis), TB, allergies, mental illness, alcoholism.

Mother

Father

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

Anything else you would like to mention?

BEFORE COMING TO CLINIC:

- Please do not wear perfume when attending the clinic.
- If you would like to know your health fund rebate amount, please check with your fund prior to the consultation.

Where did you hear about the clinic:

☐ I agree to the Terms and Conditions, found in the **Policies** section on the Booking page at https://karunahealthcare.com.au/book-appointment/

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