Choice of Living Health Centre
78 Muller Road, Greenacres, SA 5073
Phone: 8367 8228
Email: Admin@ChoiceOfLiving.com.au

Thank you for your decision to come to the Choice of Living Health Centre for your healthcare solutions. In doing so, you have expressed your commitment to your optimal health and wellness. We welcome you to our Centre for your first visit and the doctor looks forward to meeting you.

Please complete the enclosed health questionnaire. Our doctor is interested in all aspects of your health, including your family history and your past medical and surgical history. Most importantly, please tell us what the most troubling symptoms, or aspects of your health are, that you would like the doctor to focus on as a priority. The doctor will also need to review your medications and supplements, and we request that you bring these in with you for your initial visit.

1. Your first meeting is an opportunity for our doctor to gain a deeper understanding of your health challenges and issues. You will be spending time discussing your symptoms with the doctor and the effects of these on your life and wellbeing. When this meeting ends, the doctor will spend some time researching and reflecting on your health care needs, in order to fully determine how best to assist you.

2. You will need to meet with the doctor for a second time for the doctor to arrange tests and examine you. This will be an occasion for the doctor to objectively analyse various parameters that enables the doctor to gauge which areas of health are critical to your wellbeing. This will include clinic based tests, and perhaps, blood tests as well. This may also include imaging and other tests, depending on the issue of concern.

3. Finally, you will meet the doctor for the third time in order to review all your subjective and objective findings together. The doctor will explain these findings to you and we will together devise a plan of action to get you feeling your best. This plan may include seeing other practitioners, such as a dietitian, an exercise physiotherapist or a specialist. This depends on what the doctor finds and on what is suitable for you. The doctor will guide you through pharmaceutical, dietary and supplemental recommendations and will answer any questions you may have. They will arrange a review date at a later stage for follow up to ensure we are meeting your goals for your health, and will also monitor any changes and improvements at regular intervals.

Restoring full health and vitality is an exciting process. It is a process that is full of rewards. While the early stages are more intensive, as you achieve your goals, you will find that the process of maintaining optimal health and wellness simply becomes the way you live.

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Patient information

The information requested below is confidential.

Surname: _____ **First name:** _____

Address: _____

Email address: _____

DOB: _____ **Mobile #:** _____

Ethnicity: Aboriginal ☐ Torres Strait Islander ☐ Other: _____

Male ☐ **Female** ☐ **Other** ☐ **Country of birth:** _____

Usual GP and specialists seen: _____
_____

Medicare card number: _____ **Reference number:** _____ **Expiry date:** _____

Veteran's Affairs card: _____ **Expiry date:** _____

Pension / health care card: _____ **Expiry date:** _____

Next of kin: _____ **Relationship:** _____

Address: _____

Contact number: _____

Emergency contact: _____ **Relationship:** _____

Address: _____

Contact number: _____

Do you wish to be included in our recall / reminder system?	Yes ☐	No ☐
Would you like to receive SMS for appointment reminders?	Yes ☐	No ☐
Do you give permission for non-identifiable information to be included in future clinical audits, in order to enhance patient care in our practice?	Yes ☐	No ☐
Would you like to register with My Health Record?	Yes ☐	No ☐

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Medical history

Current health issues: _____

Please include sleep issues and any bowel issues

_____

_____

_____

Previous medical history: _____

Please include any history of fractures, cardiovascular issues like palpitations, infertility issues, etc. with month and year it occurred

_____

_____

_____

_____

Previous surgical history: _____

_____

_____

_____

Do you smoke? Yes ☐ No ☐ If no, please skip the next two rows.

Ex-smoker: Started smoking: _____ (year) Quitted: _____ (year)

Current smoker: Started smoking: _____ (year) No. of cigarettes daily: _____

Alcohol history: _____/drinks per day _____ /drinks per week

Do you use recreational / street drugs? Yes ☐ No ☐

If yes, what type? _____

Do you drink any of the following? Coffee ☐ Tea ☐ Soda (diet) ☐

If yes, how much daily: _____

Endocrine system

Do you have any family history of diabetes? Yes ☐ No ☐

Have you taken any medication or supplement for the thyroid? Yes ☐ No ☐

Do you have any unusual shakes or tremor? Yes ☐ No ☐

Do you have any difficulty swallowing? Yes ☐ No ☐

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Sleep history

Do you have any problem falling asleep? Yes ☐ No ☐

How many hours do you sleep? _____

What time do you go to bed and get up? _____

Do you wake up during the night? Yes ☐ No ☐ If so, how often? _____

Are you able to go back to sleep immediately? Yes ☐ No ☐

Cardiovascular and respiratory systems

Have you been admitted to a hospital due to a heart problem? Yes ☐ No ☐

Have you experienced any episodes of chest pain? Yes ☐ No ☐

Do you find it difficult to breathe if the weather is cold, or in any other situation? Yes ☐ No ☐

Do you experience shortness of breath? On exertion ☐ At rest ☐ No ☐

If you cough often, is it: Dry ☐ Productive (produces sputum) ☐ If so, please answer the next line

Sputum: Volume: _____ Colour: _____ Consistency: _____

Do you experience wheezing? Yes ☐ No ☐

If yes, please fill in the following: Times of the day: _____ Triggers: _____

Do you cough blood? Yes ☐ No ☐ **If yes, how much?** Volume: _____

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GIT and urinary systems

How often do you open your bowels? _____

How is your stool usually? Hard ☐ Pebble-like ☐ Soft ☐
Runny ☐ Watery ☐

How often do you urinate? _____/per day

Do you experience any: trouble starting ☐ trouble stopping ☐
incontinence ☐ urgency ☐

Is there any dribbling at the end of urinating? Yes ☐ No ☐

Is there any hesitancy in urinating? Yes ☐ No ☐

Muscular and skeletal systems

Do you have any muscle or joint pain / stiffness / swelling? Yes ☐ No ☐

If yes, how long have you had it: Acute ☐ Chronic ☐

Can you dress yourself completely without any difficulty? Yes ☐ No ☐

Can you walk up and down stairs without any difficulty? Yes ☐ No ☐

If yes, how does it affect your daily life? _____
_____
_____

Does it require any painkillers? Yes ☐ No ☐
If so, please state in the medication section.

Do you have skin rash / eczema? Yes ☐ No ☐

Do you bruise easily? Yes ☐ No ☐

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Neurological system

Do you have any episodes of headaches? Yes ☐ No ☐

Do you experience any numbness, pins and needles, coldness or warmth on any part of your body? Yes ☐ No ☐

Have you had any nausea or vomiting in the last two weeks? Yes ☐ No ☐

Do you have any visual disturbances? Yes ☐ No ☐

Have you experienced any altered consciousness? Yes ☐ No ☐

For women

Please describe your periods: Regular ☐ Irregular ☐
Painful ☐ Heavy ☐ Light ☐

Duration of period: _____ **Menopause:** _____ (year)

Menstrual history: At what age was your first period? _____

Age when you first used the pill? _____

Have you been sexually active in the last two years? Yes ☐ No ☐

Do you use any contraceptives? (e.g. condom) Yes ☐ No ☐

If yes, what kind: _____

Last Pap smear: _____ **Last mammogram:** _____

Number of children: _____ **Number of pregnancies:** _____

Normal vaginal delivery: _____ times **C-section delivery:** _____ times

Forceps ☐ **Suction** ☐ **Episiotomy:** _____ **Tear degree:** _____

PMT: _____ **Post-natal depression:** _____

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Preventive screening

If you are over 50 years old, when was the last time you had:

ADT immunisation: _____ **PSA test:** _____

45–49 health assessment: _____ **Stool occult blood:** _____

If you have chronic cardiovascular disease, when was your last ECG? _____

If you are over 75 years old, when was the last time you had:

75 years old health check: _____ **Chronic disease management plan:** _____

Medication and supplements

List the name of the medication and supplements you are taking, along with the dosage, frequency and how long you have been taking it. Please bring your medications and supplements with you to the consult.

Medications: _____
_____
_____
_____

Supplements: _____
_____
_____
_____

Allergies and food intolerances

Please write down what allergies and food intolerances you have, along with the known reaction and severity of reaction.

Allergies: _____
_____

Food intolerances: _____
_____

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Family history

Mother: Alive ☐ Deceased ☐ **Age of death:** _____ y/o

Cause of death: _____

Father: Alive ☐ Deceased ☐ **Age of death:** _____ y/o

Cause of death: _____

Please include history of heart problems, diabetes, high blood pressure, bone and joint problems, thyroid issues, period and pregnancy problems, asthma, stroke, high cholesterol, cancers, depression and anxiety.

Mother: _____

Father: _____

Siblings: _____

Maternal grandmother: _____

Maternal grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

Aunts: _____

Uncles: _____

Children: _____

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Social history

Occupation: _____

Disability (if any): _____

Relationship status: _____

Sexuality: _____

Living arrangements: _____
_____

Are you an elite athlete? Yes ☐ No ☐

Any other relevant information: _____
_____

Please provide your main reasons for contacting us:

_____
_____
_____
_____

I confirm that the information I have provided in this form is true, complete and accurate. I understand that the information I have provided will be recorded and kept confidential, accessed only when needed by my health care provider.

Patient signature: _____ **Date:** _____

Thank you for choosing to register with the Choice of Living Health Centre as a patient. Your information will be valuable in assisting us in providing the best individualised care for you.

Please sign the letter and return to us via email or print and bring to your next appointment with us.