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Health Questionnaire

PERSONAL DETAILS

Full name as appears on Medicare card	Preferred name	
Date of birth		
Medicare card no	Reference number ( )	Expiry date
Health Care Card /Pension no - if applicable	Expiry date	
Address		
Phone no	E-mail	
Emergency contact name and relationship	Phone number of emergency contact	

LIFESTYLE

Do you exercise routinely	☐ Yes	☐ No	If yes, what exercise and how often
Have you ever smoked	☐ Yes	☐ No	If yes, how many cigarettes per day
Do you still smoke	☐ Yes	☐ No	If no, when did you quit?
Do you drink alcohol regularly	☐ Yes	☐ No	If yes, how many drinks per week
Do you drink caffeinated coffee, teas or soft drinks regularly	☐ Yes	☐ No	If yes, how many per day
Tell us a little about our social environment (eg do you live alone, with family, single parent etc)			

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MEDICAL HISTORY

Please indicate if you suffer from the following conditions

YES	NO	CONSTITUTIONAL SYMPTOM	YES	NO	GENITOURINARY
		Recent significant weight change			Frequent urination
		Unusual fatigue or weakness			Burning or pain on urination
					Blood in urine
		Eyes			Change in force when urinating
		Change in vision			Incontinence or dribbling or urine
		Blurred or double vision			Sexual difficulties
		Eye disease or injury			**Men** – testicular pain
		Wear glasses / contact lenses			**Women** – painful periods
					Irregular periods
		Cardiovascular			Recurrent vaginal dryness
		Chest pain or angina pectoris			Number of pregnancies
		Palpitations			Method of birth control
		Shortness of breath			Date of last menstrual period
		Swelling feet, ankles or hands			Date of last pap smear
		Shortness of breath on waking			Date of last mammogram
					Breast pain
		Respiratory			Breast lump
		Recent Covid-19 infection			Breast discharge or rash
		Coughing or spitting up blood			
		Chronic or frequent cough			**Musculoskeletal**
		Shortness of breath			Joint pain / stiffness / swelling
		Asthma or recurrent wheezing			Weakness of muscles or joints
					Muscle pain or recurrent cramps
		Gastrointestinal			Back pain
		Loss of appetite			Cold hands or feet
		Change in bowel movements			Difficulty walking
		Rectal bleeding or blood in stool			
		Stomach, abdominal pain, heartburn			**Skin**
		Black or tarry stools			Skin condition
					Rashes or itching
		Endocrine			Change in skin colour or moles
		Glandular or hormone problem			Change in hair or nails
		Heat or cold intolerance			Varicose veins
		Excessive skin dryness			
		Excessive thirst or urination			**Neurological**
		Change in hand or glove size			Frequent / recurring headaches
					Migraine
		Psychiatric			Light-headedness or dizziness
		Memory loss or confusion			Convulsions, seizures or spasms
		Nervousness, anxiety, panic attacks			Numbness or tingling sensations
		Insomnia			Head injury
		Depression			

FAMILY HISTORY

Please indicate if you have a family history of the following:

Cancer	Mother	Father	Details

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Heart disease	Mother	Father	Details
Diabetes	Mother	Father	Details
High blood pressure	Mother	Father	Details
Dementia	Mother	Father	Details
Arthritis	Mother	Father	Details
Asthma	Mother	Father	Details
Skin conditions	Mother	Father	Details
Addiction	Mother	Father	Details
High cholesterol	Mother	Father	Details
Stroke	Mother	Father	Details
Depression / anxiety	Mother	Father	Details
Auto immune disease	Mother	Father	Details
Obesity / anorexia	Mother	Father	Details
Osteoporosis	Mother	Father	Details
Gastrointestinal issues	Mother	Father	Details

MEDICAL INFORMATION

Do you have any allergies	☐ Yes	☐ No	If yes, to what?
Are you allergic to any medications	☐ Yes	☐ No	If yes, to what?
Do you take any regular medications? If so, please list			
Do you take any herbal remedies or vitamins? If so, please list			
Significant past medical illnesses or injuries?			
Operations and hospitalizations. Please list surgery / admissions and approx date			

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Are you up to date with your immunizations eg tetanus, hepatitis
Have you had any recent immunizations?

HEALTH OBJECTIVES

Please list your health concerns		
What health goal/s you like to achieve?		
Which of these objectives would you like to IMPROVE? Please circle		
Energy / vitality	Sleep	Libido
Concentration / focus	Memory	Strength
Stress	Mood	Physical function
Anything else?		
Which of these symptoms would you like to REDUCE? Please circle		
Symptoms of ageing	Body fat	Mood fluctuations
Stress / anxiety	Depression	Pain / body aches
Anything else?		

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Cancellation Policy

If you are unable to attend your scheduled appointment, we request that you provide us with a minimum of 24 hours' notice. This gives us the opportunity to offer your appointment to another patient. A cancellation fee of $50 will be applied for cancellations within 24 hours. By signing this consent, I agree to the cancellation fee.

Privacy Policy

I understand that Re:Claim Health complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Re:Claim Health collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits, inclusion in national/state reminder systems/registers, to receive medical updates and health information, and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or services. I understand that I may withdraw my consent from Re:Claim Health to use and disclose my personal information (except when legal obligations must be met).

Patient signature		Date