

Integrative Health Solutions
 31 Queen Anne Street; London W1G 9HX
Confidential Patient Questionnaire

Name _____ Age _____ Birth Date ____/____/____

Address _____

City _____ Postal Code _____

Phone Home _____ Mobile _____ Work _____

Email Address _____

Preferred method of contact? _____

Would you like to receive the clinic's newsletter? **Y** **N** Electronically By Post

Person to notify in case of emergency _____ Phone _____

Employer _____ Occupation _____

Family Doctor _____ Phone _____

Address _____

NB: Copies of your consultation notes will be available to you should you wish to pass them on to other practitioners

Health History:

Please list your current health concerns:

Please list all PRESCRIPTION MEDICATIONS you are currently taking

Name of Medication	Dosage	How Often?	For How Long?	Any Known Side-Effects?

Please list all SUPPLEMENTS you currently taking

Name of Supplement	Dosage	How Often?	For How Long?	Any Known Side-Effects?



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To your knowledge, are you allergic to any...

Drugs _____

Foods _____

Environmental Allergens (pollen, dust, etc.) _____

List any hospitalizations, surgeries, and serious injuries:

When was your last complete physical exam? _____ Last Blood Test? _____

Food and Diet: (tick as appropriate)

Are you satisfied with your diet as it is now? **Y** **N**

Do you crave? Sweets Bread Fats
 Salt Chocolate Indigestible things
 Other (specify) _____

Do you regularly eat? Fish Chicken Red Meat
 Eggs Dairy/Cheese Beans/Tofu

How much water do you drink daily? _____

How much coffee/tea do you drink daily? _____

Do you drink alcohol? **Y** **N** If yes, how much and how often? _____

Do you smoke? **Y** **N** **PAST** If so, how much and for how long? _____

Do you consume any recreational drugs? **Y** **N** _____

24 Hour Diet Recall

Please list everything you ate yesterday.

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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Sleep:

Usually, what time do you usually go to bed? _____ Wake up? _____

Do you sleep well? **Y** **N** Wake rested and refreshed? **Y** **N**

Do you wake in the night? _____ Why? _____

Exercise:

Do you exercise? **Y** **N** How often/long? _____

Please describe _____

Social History:

Are you... Single Partnered/Married Separated Divorced Widowed?

Spouse's name (if applicable) _____

Do you have children? Ages? _____

Who lives with you at home? _____

Is there someone to help with your medical treatment if necessary? _____

Family History

List any close blood relatives affected by:

M for mother, **F** for Father, **B** for brother, **S** for Sister

Alcoholism _____ Heart disease _____

Allergies _____ High Blood Pressure _____

Arthritis _____ Kidney disease _____

Asthma _____ Mental Illness _____

Cancer _____ Stroke _____

Diabetes _____ Tuberculosis _____

Epilepsy _____ Other _____

Is there anything else, you think we should know about your health at this time?



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Review of Systems -1

Circle 0 for conditions which DO NOT apply to you.

Circle 1 for mild/rarely, 2 for moderate/regularly, 3 for severe/frequently, or P for past.

General

Height _____
Weight _____
Maximum Weight _____
Fatigue 0 1 2 3 P
Pain 0 1 2 3 P
Stress 0 1 2 3 P
Allergies 0 1 2 3 P

Skin

Rash or Growths 0 1 2 3 P
Changes in Hair or Nails 0 1 2 3 P
Eczema or Psoriasis 0 1 2 3 P
Itching 0 1 2 3 P

Eyes

Impaired Vision 0 1 2 3 P
Eye Pain 0 1 2 3 P
Tearing or Dryness 0 1 2 3 P
Halos around lights 0 1 2 3 P
Conjunctivitis 0 1 2 3 P
Glaucoma 0 1 2 3 P

Ears

Hard of Hearing 0 1 2 3 P
Ringing 0 1 2 3 P
Earache 0 1 2 3 P

Nose & Sinuses

Seasonal Allergies 0 1 2 3 P
Nose Bleeding 0 1 2 3 P
Sinus Problems 0 1 2 3 P
Stuffy or Runny Nose 0 1 2 3 P

Mouth & Throat

Sore Throat 0 1 2 3 P
Cold Sores 0 1 2 3 P
Hoarseness 0 1 2 3 P
Gingivitis 0 1 2 3 P
Periodontal Disease 0 1 2 3 P
Number of Amalgam Fillings _____

Digestion

Difficulty Swallowing 0 1 2 3 P
Belching 0 1 2 3 P
Heartburn, Stomach Pain 0 1 2 3 P
Excessive Thirst or Hunger 0 1 2 3 P
Loss of Appetite 0 1 2 3 P
Nausea or Vomiting 0 1 2 3 P
Loose Stools 0 1 2 3 P
Hard Stools 0 1 2 3 P
Strain to pass stool 0 1 2 3 P
Blood in Stool or on Paper 0 1 2 3 P
Black or Tarry Stools 0 1 2 3 P
Haemorrhoids 0 1 2 3 P

Urinary

Pain with Urination 0 1 2 3 P
Increased Frequency 0 1 2 3 P
Up at Night to Urinate 0 1 2 3 P
Start-Stop Stream / Dribbling 0 1 2 3 P
Urinary Tract Infections 0 1 2 3 P

Respiratory

Frequent Colds / Flu 0 1 2 3 P
Cough 0 1 2 3 P
Shortness of Breath 0 1 2 3 P
Wheezing 0 1 2 3 P
Asthma 0 1 2 3 P
History of Tuberculosis Y N

Neurological & Cognitive

Headache 0 1 2 3 P
Dizziness 0 1 2 3 P
Loss of Consciousness 0 1 2 3 P
Seizures 0 1 2 3 P
Muscle Weakness 0 1 2 3 P
Numbness or Tingling 0 1 2 3 P
Head Injury 0 1 2 3 P
Memory Loss 0 1 2 3 P
Difficulty Concentrating 0 1 2 3 P
Absent Minded 0 1 2 3 P
Dyslexia 0 1 2 3 P



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Review of Systems – 2

Circle 0 for conditions which DO NOT apply to you.

Circle 1 for mild/rarely, 2 for moderate/regularly, 3 for severe/frequently, or P for past.

Endocrine / Hormones

Thyroid Problems 0 1 2 3 P
Cold Hands and Feet 0 1 2 3 P
Heat or Cold Intolerance 0 1 2 3 P
Easy Weight Gain 0 1 2 3 P
Weight Gain in Stomach 0 1 2 3 P
Unexplained Weight Loss 0 1 2 3 P
Dizzy on Standing Up 0 1 2 3 P
Increased Thirst 0 1 2 3 P
Energy drop 2-4 hrs after meal 0 1 2 3 P

Cardiovascular

Heart Disease 0 1 2 3 P
High Blood Pressure 0 1 2 3 P
Rheumatic Fever 0 1 2 3 P
Heart Palpitations / Fluttering 0 1 2 3 P
Varicose Veins 0 1 2 3 P
Chest Pain 0 1 2 3 P
Swollen Ankles 0 1 2 3 P
Easy Bruising or Bleeding 0 1 2 3 P

Musculo-Skeletal

Joint Stiffness or Pain 0 1 2 3 P
Muscle Pain 0 1 2 3 P
Back Pain 0 1 2 3 P
Muscle Weakness 0 1 2 3 P
Radiating pain 0 1 2 3 P
Deep Leg Pain 0 1 2 3 P
Arthritis 0 1 2 3 P
Bursitis 0 1 2 3 P

Emotional

Mood Swings 0 1 2 3 P
Depression 0 1 2 3 P
Winter Depression 0 1 2 3 P
Anxiety or Nervousness 0 1 2 3 P
Tension 0 1 2 3 P
Feelings of Anger or Hostility 0 1 2 3 P
Lack of Purpose 0 1 2 3 P
Happy and Satisfied with Life 0 1 2 3 P
Think about Suicide 0 1 2 3 P

Reproductive Health

Are you sexually active Y N
Do You Practice Safer Sex Y N
Sexual Dysfunction 0 1 2 3 P
Birth Control 0 1 2 3 P
Sexually Transmitted Disease 0 1 2 3 P
Decreased Sexual Desire 0 1 2 3 P
Hernia 0 1 2 3 P

Male Reproductive Health

Testicular Pain 0 1 2 3 P
Testicular Mass or Lump 0 1 2 3 P
Prostate Problems 0 1 2 3 P

Female Reproductive Health

Age of First Menstruation _____
Do You Still Menstruate Y N
Date/Age Menses Stopped _____
Number of Days of Flow _____
Length of Menstrual Cycle _____
Date Last Menses Began _____
Heavy Bleeding 0 1 2 3 P
Bleeding Between Periods 0 1 2 3 P
Pre-Menstrual Tension 0 1 2 3 P
Menstrual Cramping 0 1 2 3 P
Swollen or Painful Breasts 0 1 2 3 P
Date of Last PAP Smear _____
Abnormal PAP Smear (ever) Y N

Number of Pregnancies _____
Number of Births _____
Difficulty Conceiving Y N
Pain on Intercourse 0 1 2 3 P

Regular Breast Self Exam? Y N

Today's Date _____



Signed _____