Darling Street Health Centre  
1/449 Darling Street   
Balmain 2041  
9555 8806  
  
Natural Wisdom



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0400 551 622

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific reason for your appointment and other current health concerns:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Recent pathology/tests/investigations/operations etc:

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Have you experienced major stress in the last 12 months? (for example, death in the family, divorce, bankruptcy)

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General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

|  |  |  |  |
| --- | --- | --- | --- |
| Gastro-intestinal  🞎 Bloating  🞎 Flatulence  🞎 Reflux/Heartburn  🞎 Indigestion  🞎 Nausea  🞎 Abdominal pain  🞎 Constipation  🞎 Diarrhea  🞎 Food intolerances | Respiratory  🞎 Persistent cough  🞎 Sneezing, wheezing  🞎 Post nasal drip  🞎 Ear infections  🞎 Itchy eyes, ears, nose, throat  🞎 Sore throat | Skin  🞎 Slow wound healing  🞎 Acne  🞎 Psoriasis  🞎 Dry, flaky skin  🞎 Oily skin  🞎 Eczema / skin rashes | Cardiovascular  🞎 Excessive fatigue  🞎 Shortness of breath  🞎 Easy bruising or bleeding  🞎 Palpitations  🞎 Dizziness  🞎 Varicose veins  🞎 High blood pressure  🞎 High cholesterol |
| Immune/Lymphatic  🞎 Poor immunity  🞎 Recurrent cold / flu  🞎 Hayfever / sinusitis  🞎 Fluid retention  🞎 Cold sores  🞎 Inflammed / bleeding gums  🞎 Auto-immune disease  🞎 Cancer | Sleep  🞎 Insomnia  🞎 Difficulty falling asleep  🞎 Waking during night  🞎 Waking un-refreshed  🞎 Regular dreaming  🞎 Night sweats | Emotional  🞎 Depression  🞎 Anxiety  🞎 Mood swings  🞎 Poor memory  🞎 High stress levels  🞎 Feelings of being overwhelmed or unable to cope | Musculoskeletal  🞎 Headaches  🞎 Migraines  🞎 Muscle aches or cramps  🞎 Joint pain  🞎 Restless legs  🞎 Muscle weakness |
| Endocrine  🞎 Fatigue / poor energy  🞎 Recent weight gain  🞎 Heat / cold intolerance  🞎 Hair falling out  🞎 Abdominal weight gain  🞎 Thyroid disorder | Urinary / Renal  🞎 Excessive urination  🞎 Frequent urination  🞎 Pain with urination  🞎 Incontinence  🞎 Bloody, cloudy or smelly urine🞎 Urinary tract infection | Male hormone balance  🞎 Low libido  🞎 Difficulty starting urine flow  🞎 Premature ejaculation  🞎 Difficulty maintaining erection  🞎 Genital rash or irritation  🞎 Painful testicles | Female hormone balance  🞎 Hot flushes  🞎 Night sweats  🞎 Change in menstrual cycle  🞎 Dry hair, skin or vagina  🞎 Low libido  🞎 Excessive libido  🞎 Bleeding after intercourse  🞎 Infertility  🞎 Miscarriage |
| Pre-menstrual symptoms (women only)  🞎 Depressed or teary  🞎 Anxious or irritable  🞎 Feeling aggressive or angry  🞎 Breast tenderness  🞎 Food cravings  🞎 Fluid retention/bloating  🞎 Back pain  🞎 Abdominal pain  🞎 Headaches or migraines | Menstrual symptoms (women only)  🞎 Long intervals between cycles  🞎 Cycles longer than 32 days  🞎 Cycles shorter than 24 days  🞎 Heavy blood flow or flooding  🞎 Passing of blood clots  🞎 Very light blood flow  🞎 Spotting before or after bleed  🞎 Period pain | Sexual Health  🞎 Thrush  🞎 Genital herpes  🞎 Sexually transmitted disease  🞎 Irregular pap smear  🞎 Painful intercourse  🞎 Burning or itching pain on genitals | Lifestyle  🞎 Smoker \_\_\_\_\_ / day  🞎 Passive smoker  🞎 Coffee \_\_\_\_\_\_\_/ day  🞎 Tea \_\_\_\_\_\_\_/ day  🞎 Alcohol \_\_\_­­\_\_ /week  🞎 Recreational drugs  🞎 Exercise \_\_\_ / week  🞎 Excessive plane travel  🞎 Radiation exposure  🞎 Pesticide / herbicide exposure  🞎 Bleach and ammonia use (cleaning)  🞎 High stress levels |

Please list any health concerns of family members including siblings, parents and grandparents:

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Current medications (including dosage):

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Current supplements (dose and brand):

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