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

Natural Wisdom



220a Glenmore Rd

Paddington 2021
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:

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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.

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| --- | --- | --- | --- |
| 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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