Initial Visit Form

This questionnaire includes additional information, which may be important or relevant to your management. Please answer these questions as accurately as possible.

Your Details:

Name: _____Date of Birth: _____ Sex: M / F
First Middle Last

Address: _____ State: _____ Postcode: _____

Telephone: (Home) ( ) _____(Mob) _____ (Work) _____

Email:_____

Current occupation _____If retired, past occupation_____

Medicare no _____ Expiry _____

Pension/Health Care _____ Expiry _____

DVA no _____ Expiry _____

Name of Health Fund _____Membership no _____

Your General Practitioner Name _____

Your Next of Kin

Name: _____ Address: _____

Suburb: _____ _____ Postcode: _____ Telephone: _____ Relationship: _____

****

Please tick (✓) if you have experienced any of the following over the last six months:

	fever		problems with urination
	weight loss (more than 4 kg)		abnormal vaginal bleeding
	loss of appetite		gynaecological (female) problems
	skin rash		muscle weakness
	other skin problems		numbness /tingling of hands/feet
	loss of hair		swelling of hands
	Bleeding or bruising		colour change in fingers
	dry eyes		recent coughs/cold/flu like illness
	other eye problems		trouble swallowing
	stuffy nose / sinusitis		Heartburn / acid reflux
	sores in the mouth		stomach pain or cramps
	dry mouth		Diarrhoea/blood/mucous in stool
	cough / phlegm		
	shortness of breath		
	pain in the chest		

Please list below all major illnesses or admissions to a hospital (including operations):

Illness or reason for hospitalisation	Year	Hospital, City State
1.		
2.		
3.		
4.		

Please turn to next page

Please tick if you have you ever had: **If you answer "Yes", please write AGE or YEAR when it began below:**

	✓	Age or Year		✓	Age or Year
high blood pressure			rheumatoid arthritis		
heart attack (how many?)			osteoarthritis		
angina (how often?)			lupus		
other heart disease			back or spine problems		
high cholesterol (how high?)			fibromyalgia (fibrositis)		
cancer			osteoporosis		
Stroke/TIA			broken bones after age 50		
bronchitis or emphysema			dry mouth		
asthma			cataracts		
other lung problem			Parkinson's disease		
anaemia (low blood count)			depression		
other blood problem			mental illness or alcoholism		
stomach ulcer			severe allergies		
other gut problem			psoriasis		
thyroid problem			blood clots		
diabetes			peripheral vascular disease		
kidney problem			leg ulcers		
miscarriage			carpal tunnel syndrome		
gynaecological (female)			gout		
prostate (male) problem			Other……..		

The questions below concern your family medical history

	If living		If Deceased	
	Age (s)	Any major medical conditions	Age (s) at Death	Cause(s) of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

Any blood relative (parent, child, brother, sister, aunt, uncle) with: If "yes" give relationship

	No	**Yes**	**Relation(s)**
Rheumatoid arthritis			
Heart attack or stroke before age 65			
Lupus or SLE			

Any illnesses which run in the family? _____

Have you ever smoked? Yes / No If yes, approximate number per day? _____

How many years have you smoked? _____If stopped, when_____

How much alcohol do you drink? _____

Marital Status (tick appropriate) Single☐ Married ☐ Divorce ☐ Widowed ☐ Separated ☐

If married – health of spouse Good ☐ Poor ☐ If Poor, give details: _____

Health of others living at home Good ☐ Poor ☐ If Poor, give details: _____

Thank you, End of Questionnaire.