THE NATURAL PRACTICE

New Patient Questionnaire

Please complete this form using CAPITAL LETTERS and bring it with you to your first appointment.
This information is confidential and will form part of your medical notes. Please provide us with additional information if necessary.

Title: Mr / Ms / Mrs / Miss / Other: (please specify) ……

First Names …….. Last Name……

Date of birth …… Parents or Guardian's name (if under 16) -

Address ……

…… Post Code …….

Home tel..…… Work tel……... Mobile ……...

Email address …….
Occupation……
If you wish for any medication to be sent to a different address than above please put the address here……

…… Post Code …….

Marital Status: (please tick) Single ☐ Cohabiting ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Partnership☐

Ages of children (if applicable) ……

Do you have medical insurance? (please tick) YES ☐ NO ☐,
If able do you intend to claim on your insurance? (please tick) YES ☐ NO ☐
If yes, please provide insurer's name ……
If you are being funded by the NHS or a Health Authority, please provide their name ……

Would you like us to write to your GP (please tick) YES ☐ NO ☐ NOT AT PRESENT ☐

GP's Name …….. GP's telephone ……..

Surgery Address …….

Do you require a chaperone if you need to be examined (please tick) YES ☐ NO ☐

1. History of Current Problem

In the space below, please outline the problem(s) that have led to your visit. You should mention all significant complaints, as there may be a relationship between them.

Problem	**Onset**	**Frequency**	**Severity** (mild/moderate/severe)
eg Stomach pains ……	eg June 1995	eg 4 x week…….	eg Moderate ……
……	……..	……..	……
……	……..	……..	……
……	……..	……..	……
……	……..	……..	……

What diagnoses or explanations have been given to you, if any?

……

2. Your Medical History

i) Illnesses: If you have had any of the following, please tick the box and state when

Tuberculosis	☐ ……	Diabetes	☐ ……
Rheumatic fever	☐ ……	High blood pressure	☐ ……
Hepatitis / Jaundice	☐ ……	Chicken pox	☐ ……
Measles	☐ ……	Mumps	☐ ……
Glandular fever	☐ ……	German measles	☐ ……
Reaction to a vaccine	☐ ……	Depression / anxiety	☐ ……

Please list any other significant past illnesses or problems (stating approximately when)

e.g. **Allergies**, heart disease

……

……

ii) Operations: Please list any operations you have had (stating approximately when)

e.g. tonsillectomy, hernia, gall bladder, hysterectomy, appendectomy

……

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iii) Diagnostic investigations: Please list any that you have had (stating approximately when)

e.g. chest X-ray, endoscopy, mammogram, ECG, angiogram

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iv) Injuries: Please list any major injuries you have suffered (stating approximately when)

e.g. head injury, back injury, broken leg/arm, road traffic accident

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v) Medication: Please list and include other current treatments

You should include any nutritional supplements, homeopathic remedies or other treatments eg osteopathy etc.

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3. Your General Health

If you suffer, or have suffered, from any of the following, please tick the box

i) General / Emotional

Low energy	☐	Tearful	☐	Absent / decreased enjoyment of life	☐
Poor memory	☐	Depressed	☐	Wake early and cannot get back to sleep	☐
Very angry lately	☐	Low sex drive	☐	Unsatisfying close emotional relationships	☐
Poor concentration	☐				

ii) Digestion

Abdominal pain	☐	Symptoms worse after eating	☐	Tiredness after meals	☐
Rectal bleeding	☐	Symptoms better if you have not eaten	☐	Rectal mucus or slime	☐
Abdominal bloating	☐	Symptoms worse if meals missed	☐		

Frequency of satisfactory bowel movement:

Once a week	☐	Once every 2 days	☐	Once a day	☐	Other ……	

iii) Respiratory

Persistent cough	☐	Wheeze	☐	Abnormal shortness of breath	☐
Coughing blood	☐	Phlegm	☐	Runny nose	☐

iv) Skin

Sensitivity problems	☐	Infections	☐	Rashes	☐	Itch	☐	Ulcers	☐

v) Central Nervous System

Headaches	☐	Fits	☐	Loss of consciousness	☐
Visual disturbances	☐	Faints	☐	Loss of power in an arm or leg	☐
‘Brain fog’ (fuzzy head, poor memory)			☐	Pins and needles in arm or leg	☐

vi) Genitourinary System

Impotency problems	☐	Lack of sexual desire	☐
Pain or burning while passing urine	☐	Passing urine more than twice per night	☐
Trouble stopping or starting urination	☐		

vii) Gynaecological

Breast tenderness	☐	Pain during sexual intercourse	☐
Premenstrual abdominal bloating	☐	Persistent vaginal discharge	☐
Period pain (mild / moderate / severe)	☐	Premenstrual mood changes (mild / moderate / severe)	☐

4. Family Medical History

Please complete the following information if known:

	Age	Alive/Deceased	If deceased, cause of death
Mother	…….	…….	……
Father	…….	…….	……
Brother / Sister	…….	…….	……
Brother / Sister	…….	…….	……
Brother / Sister	…….	…….	……

Any known family history of: (please tick)

Heart disease ☐ Jaundice ☐ Rheumatic fever ☐ Diabetes ☐ Tuberculosis ☐ Epilepsy ☐

5. Other Relevant Information

What is your occupation? ……

How much stress is involved? None ☐ Moderate ☐ Severe ☐

Do you enjoy your job? Love it ☐ It's okay ☐ Don't like it ☐ Hate it ☐

How much time have you lost from work/school in past year? ……..

Please list any previous jobs ……

Do you smoke cigarettes? YES / NO How many per day? …….. For how many years? …….

Do you drink alcohol? YES / NO How many drinks per day/week? (specify which) ……..

How many cups of tea and coffee do you drink per day? ……..

What pets live with you? ……...

Are they: Indoors ☐ Outdoors only ☐

Have you lived or travelled outside the UK? If so, please state when and where …….

……

Do you, or have you, used drugs recreationally? Yes ☐ No ☐

Have you had any sexually transmitted diseases? Yes ☐ No ☐

If yes, please specify ……

Any other comments/information which you feel may be important ……..

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Updated June 2013