



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 Moderate
eg Stomach pains	eg June 1995	eg 4 x week.....	eg Moderate
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.....
.....
.....

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

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2. Your Medical History

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

- | | | | | | |
|-----------------------|--------------------------|-------|----------------------|--------------------------|-------|
| Tuberculosis | <input type="checkbox"/> | | Diabetes | <input type="checkbox"/> | |
| Rheumatic fever | <input type="checkbox"/> | | High blood pressure | <input type="checkbox"/> | |
| Hepatitis / Jaundice | <input type="checkbox"/> | | Chicken pox | <input type="checkbox"/> | |
| Measles | <input type="checkbox"/> | | Mumps | <input type="checkbox"/> | |
| Glandular fever | <input type="checkbox"/> | | German measles | <input type="checkbox"/> | |
| Reaction to a vaccine | <input type="checkbox"/> | | Depression / anxiety | <input type="checkbox"/> | |

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

e.g. Allergies, heart disease

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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 | <input type="checkbox"/> | Tearful | <input type="checkbox"/> | Absent / decreased enjoyment of life | <input type="checkbox"/> |
| Poor memory | <input type="checkbox"/> | Depressed | <input type="checkbox"/> | Wake early and cannot get back to sleep | <input type="checkbox"/> |
| Very angry lately | <input type="checkbox"/> | Low sex drive | <input type="checkbox"/> | Unsatisfying close emotional relationships | <input type="checkbox"/> |
| Poor concentration | <input type="checkbox"/> | | | | |

ii) Digestion

- | | | | | | |
|--------------------|--------------------------|---------------------------------------|--------------------------|-----------------------|--------------------------|
| Abdominal pain | <input type="checkbox"/> | Symptoms worse after eating | <input type="checkbox"/> | Tiredness after meals | <input type="checkbox"/> |
| Rectal bleeding | <input type="checkbox"/> | Symptoms better if you have not eaten | <input type="checkbox"/> | Rectal mucus or slime | <input type="checkbox"/> |
| Abdominal bloating | <input type="checkbox"/> | Symptoms worse if meals missed | <input type="checkbox"/> | | |

Frequency of satisfactory bowel movement:

- Once a week Once every 2 days Once a day Other

iii) Respiratory

- | | | | | | |
|------------------|--------------------------|--------|--------------------------|------------------------------|--------------------------|
| Persistent cough | <input type="checkbox"/> | Wheeze | <input type="checkbox"/> | Abnormal shortness of breath | <input type="checkbox"/> |
| Coughing blood | <input type="checkbox"/> | Phlegm | <input type="checkbox"/> | Runny nose | <input type="checkbox"/> |

iv) Skin

- Sensitivity problems Infections Rashes Itch Ulcers

v) Central Nervous System

- | | | | | | |
|---------------------------------------|--------------------------|--------|--------------------------|--------------------------------|--------------------------|
| Headaches | <input type="checkbox"/> | Fits | <input type="checkbox"/> | Loss of consciousness | <input type="checkbox"/> |
| Visual disturbances | <input type="checkbox"/> | Faints | <input type="checkbox"/> | Loss of power in an arm or leg | <input type="checkbox"/> |
| 'Brain fog' (fuzzy head, poor memory) | <input type="checkbox"/> | | | Pins and needles in arm or leg | <input type="checkbox"/> |

vi) Genitourinary System

- | | | | |
|--|--------------------------|---|--------------------------|
| Impotency problems | <input type="checkbox"/> | Lack of sexual desire | <input type="checkbox"/> |
| Pain or burning while passing urine | <input type="checkbox"/> | Passing urine more than twice per night | <input type="checkbox"/> |
| Trouble stopping or starting urination | <input type="checkbox"/> | | |

vii) Gynaecological

- | | | | |
|--|--------------------------|--|--------------------------|
| Breast tenderness | <input type="checkbox"/> | Pain during sexual intercourse | <input type="checkbox"/> |
| Premenstrual abdominal bloating | <input type="checkbox"/> | Persistent vaginal discharge | <input type="checkbox"/> |
| Period pain (mild / moderate / severe) | <input type="checkbox"/> | Premenstrual mood changes (mild / moderate / severe) | <input type="checkbox"/> |

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