Modern Health

Medical Questionnaire

(Please fill form and bring to your appointment)

Today's Date (dd/mm/yyyy)

Patient Ref

Personal Details:

Title
- Mr
- Mrs
- Miss
- Dr

First Name

Surname

Sex
- F
- M

Date of birth

Height (cm / ft)

Weight (kg / lb)

Blood pressure

Pulse

Address

Post Code

Occupation

Telephone Number

Mobile number

Main Symptom

Environment Details:

Do you live in the country?
- Yes
- No

Is there gas in your home?
- Yes
- No

Are there coal fires in your home?
- Yes
- No

Do you smoke?
- Yes
- No

Do you live near a main road?
- Yes
- No

Are there any smokers in the family?
- Yes
- No

Where do you shop?

Tick the boxes of those which have occurred regularly over the past year

- WOMEAN ONLY -

Menopause

Menstrual cycle
- Regular
- Irregular
- Amenorrhoea
- Painful

Cysts
- Breast
- Ovarian

Toxaemia of pregnancy

Contraceptive pill — Dates:

Pregnancy — Dates:

Miscarriage — Dates:

continued over . . . .

Tick the boxes of those which have occurred regularly over the past year

- Overweight
- Underweight
- Fluctuating weight
- Abdominal cramps
- Nausea
- Diarrhoea
- Constipation
- Bloating after meal
- Flatulence
- Colitis
- Weeping eyes
- Itching eyes
- Visual problems
- Sneezing
- Sinusitis
- Itching nose
- Runny nose
- Post-nasal drip
- Sore throat
- Hoarseness
- Cough
- Catarrh
- Wheezing
- Bronchitis

- Cold
- Hot
- Sweating
- Breathlessness
- Frequent urination
- Water retention
- Dark puffy circles under the eyes
- Fibrositis
- Fatigue for no reason
- Waking up tired
- Clumsiness
- Floating feeling
- Tenseness
- Headaches (tension)
- Nervousness
- Insomnia
- Waking during night
- Hypoactive
- Hyperactive
- Hysterical
- Mental confusion
- Mouth ulcers
- Tingling lips
- Cramps
- Inability to concentrate

- Forgetfulness
- Depression
- Anxiety state
- Irritability
- Aggressiveness
- Cannot miss or be late for a meal
- Obsessional eating
- Eating for comfort
- Craving a specific food
- Poor appetite
- High blood pressure
- Low blood pressure
- Were you ever bottle fed?

When are you worse:

- Spring
- Summer
- Autumn
- Winter
- At home
- At work
- On holiday
- First thing in the morning
- Day time
- Night time
- Before meals
- After meals
- After shopping
- In heavy traffic
- All the time

Skin

- Itching
- Burning
- Urticaria
- Itching scalp
- Dandruff

Pulse

- Fast
- Slow

Aching muscles

- Joints
- Back

Have you ever taken cortisone?

- Yes
- No

Ears

- Ringing
- Aching

Drowsiness

- Especially after meals

Operations (list with dates)

Diagnosis

- Migraine
- Myxoedema
- Ulcerative Colitis
- Multiple Sclerosis
- Agoraphobia
- Osteoarthritis
- Rheumatoid Arthritis
- Asthma
- Schizophrenia
- Thyrotoxicosis

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Brief history of past illnesses (other than normal childhood)

Other illness(es)

List of known allergies (including drugs)

Family history

What drugs/medicines are you taking now?

Do you agree to having your doctor notified?

Yes

No

Name of your doctor

Address

Telephone number

How often, if at all, do you consume the following

	Never	Infrequently	Sometimes	Regularly / Daily	Frequently
Bread					
Coffee					
Tea					
Alcoholic drinks					
Chocolate					
Sugar (cane) brown					
Oranges					
Corn and corn products					
Pork / bacon					
Preserved meats					
Milk					
Cheese					

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How often, if at all, do you consume the following

	Never	Infrequently	Sometimes	Regularly / Daily	Frequently
Cake or biscuits					
Eggs					
Potatoes					
Beetroot or beet sugar (white)					
Tomatoes					
Cereals / breakfast foods					
Fish					
Beef					
Lamb					
Salt					
Nuts					
Soft drinks					
Root vegetables					

Please answer the following

Is there any food that you eat at least once a day (or crave for)?

Yes

No

If yes, please list

Do you eat regularly?

Yes

No

How many times per day do you eat?

Is there any food you dislike?

Yes

No

If yes, please list

Is there any food that you avoid because it disagrees with you?

Yes

No

If yes, please list

Do you eat out?

Yes

No

If yes, how often?

When you were a child were there any foods you disliked, or felt ill after eating?

Yes

No

If yes, please list

Since your symptoms started, have you increased your intake of any food?

Yes

No

Do traffic fumes upset you?

Yes

No

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Do crop sprays or pesticides affect you?

Yes

No

Do gas fumes upset you?

Yes

No

Do enclosed shopping areas affect you?

Yes

No

Describe a typical day's diet

Breakfast

Tea

Lunch

Dinner

Snacks / Other foods