NATURE CARE
HEALTH

CONFIDENTIAL PATIENT QUESTIONNAIRE

Please complete the following questionnaire. Your response remains confidential and will provide information for your practitioner to use in your assessment and treatment.

Title		Date of Birth	
First / Second Names		Surname	
Home Address			
Suburb/Town		State	Postcode
Home: ( )	Work: ( )	Mobile:	
Medicare Number	Ref (exp.)		
Email Address			
Height (cm)	Weight (kg)		
Next of Kin	Relationship	Telephone No:	

GENERAL DETAILS

Please list the main problems you are experiencing and/or reasons for this appointment.

What do you believe the problem may be due to?

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When was the last time you felt truly well?

What do you expect from your consultation today?

What do you think can help you?

PAST MEDICAL HISTORY
Please circle as appropriate.

Illness/Medical Problem	**Present**	**Past**
Heart/Vascular Disorder	YES	YES
Blood disorder	YES	YES
High blood pressure	YES	YES
Cancer	YES	YES
Arthritis	YES	YES
Diabetes	YES	YES
Liver disease	YES	YES

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Kidney disease	YES	YES
Asthma	YES	YES
Epilepsy	YES	YES
Hepatitis	YES	YES
Glandular fever	YES	YES
Sexually Transmitted Diseases *Please specify.*	YES	YES
Other conditions *Please specify.*	YES	YES
Operations *Please specify.*	YES / NO	YES / NO
Pregnancies	YES / NO	YES / NO
Exposure to chemicals or toxins *Please specify.*	YES / NO	YES / NO
Frequent Antibiotic Use	YES / NO	YES / NO
Previous long-term medications (including contraceptive pill)	YES / NO	YES / NO

SCREENING/PATHOLOGY HISTORY

Screening Test / Pathology	Date	Result
Mammogram / Breast Ultrasound		
Pap Smear		
Bone Density		
Cholesterol		
PSA (Prostate Blood Test)		

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NUTRITIONAL SUPPLEMENTS (vitamins, minerals etc.), HERBAL MEDICINES, HOMOEOPATHIC REMEDIES

Name	Dosage

CURRENT MEDICATIONS (prescription and non-prescription)

Name	Dosage

ALLERGIES / SENSITIVITIES (including medications, foods, dust mites, grasses, chemicals)

Allergies / Sensitivities	Treatment

SOCIAL HISTORY

Occupation	

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Marital Status	
Cigarettes / Tobacco (strength & amount/day)	
Alcohol (type & amount/day)	
Recreational Drugs	
Exercise (type, duration & frequency)	
Relaxation Techniques (e.g. meditation, yoga, tai chi)	

DIET

Do you follow a specific type of diet? *Please circle.*	**YES / NO**
If yes, please specify. *(eg. Low fat, low carbohydrate, blood group, vegetarian etc.)*	

What did you eat yesterday? *Please complete the table on the following page*

Breakfast			
Lunch			
Dinner			
Snacks			
Sugar (tsp/day)	Tea (cups/day)	Coffee (cups/day)	Soft Drinks(per day)
Water (glasses/day)		Other Drinks	

Was this a typical day? *Please circle*. YES / NO

Please list the foods that you **CRAVE**.	Please list the foods that you **AVOID**.

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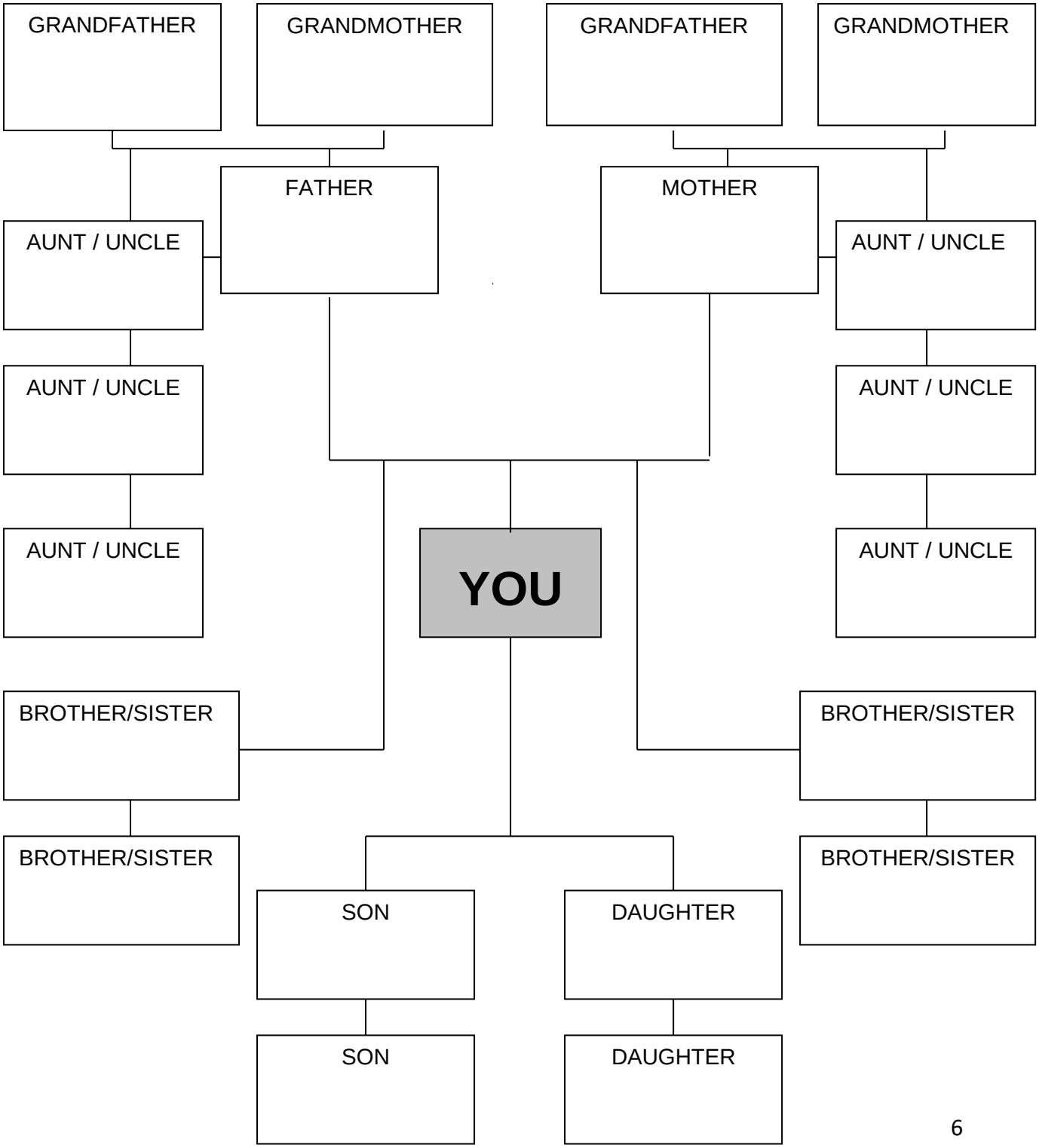
Please complete the chart below indicating only chronic or significant illnesses (eg. Cancer, diabetes, asthma, arthritis, heart disease and blood pressure) within the appropriate box on the family medical history tree.

FAMILY HISTORY



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METABOLIC SCREENING QUESTIONNAIRE

Please rate each of the following symptoms based upon your health profile for the past 30 days.
0 = Never or almost never have the symptom.
1 = Occasionally have it, effect is not severe.
2 = Occasionally have it, effect is severe.
3 = Frequently have it, effect is not severe.
4 = Freqently have it, effect is severe.

DIGESTIVE TRACT	___ Nausea or vomiting ___ Diarrhea ___ Constipation ___ Bloated Feeling ___ Belching, or passing gas ___ Heartburn ___ Intestinal / Stomach pain	**Total** ___
EARS	___ Itchy Ears ___ Earaches, ear infections ___ Drainage from ears ___ Ring in ears, hearing loss	**Total** ___
EMOTIONS	___ Mood swings ___ Anxiety, fear or nervousness ___ Anger, irritability, or aggressiveness ___ Depression	**Total** ___
ENERGY / ACTIVIY	___ Fatigue, slugglishness ___ Apathy, lethargy ___ Hyperactivity ___ Restlessness	**Total** ___
EYES	___ Watery or itchy eyes ___ Swollen, reddened or sticky eyelids ___ Bags or dark circles under eyes ___ Blurred or tunnel vision (does not include near or far sightedness)	**Total** ___
HEAD	___ Headaches ___ Faintness ___ Dizziness ___ Insomnia	**Total** ___
HEART	___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat ___ Chestpain	**Total** ___
JOINTS / MUSCLES	___ Pain or aches in joints ___ Arthritis ___ Stiffness or limitation of movement ___ Pain or aches in muscles ___ Feeling of weakness or tiredness	**Total** ___
LUNGS	___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficulty breathing	**Total** ___
MIND	___ Poor Memory ___ Confusion poor comprehension ___ Poor Concentration	**Total**

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	___ Poor physical co ordination ___ Difficulty in making decisions ___ Stuttering or stammering ___ Slurred speech ___ Learning disabilities	___
MOUTH / THROAT	___ Chronic coughing ___ Gagging, frequent need to clear throat ___ Sore throat, hoarseness, loss of voice ___ Swollen or discoloured tongue gums, lips ___ Canker sores	**Total** ___
NOSE	___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucus formation	**Total** ___
SKIN	___ Acne ___ Hives, rashes, or dry skin ___ Hair loss ___ Flushing or hot flushes ___ Excessive sweating	**Total** ___
WEIGHT	___ Binge eating / drinking ___ Craving certain foods ___ Excessive weight ___ Compulsive eating ___ Water retention ___ Underweight	**Total** ___
OTHER	___ Frequent illness ___ Frequent or urgent urination ___ Genital itch or discharge	**Total** ___
GRAND TOTAL		___
COMMENTS:		

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General Acknowledgement and Consent Form

I understand that some of the diagnostic tests, treatments and products administered by Dr Varipatis at **Nature Care Health** may be outside the parameters of conventional medicine in Australia. They fall into the category of Natural or Complementary Medicine. I understand that these diagnostic tests, treatments and products are supported by empirical knowledge, are safe, are widely and successfully used by Integrative Medical practitioners in centres in Australia and overseas, and are only prescribed with utmost care. Some diagnostic tests and treatments offered by Dr Varipatis are not covered by Medicare or private health insurance funds. Dr Varipatis is a members and active participant of their respective professional Colleges and Associations.

I am attending Nature Care Health to see Dr Varipatis of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me. I understand that Dr Varipatis may recommend and dispense items that are yet to be regulated by the Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, Dr Varipatis will make me fully aware of those risks and provide me with sufficient information to make an informed decision.

I consent to receive the following electronic reminders/voice messages:

☐ Appointments ☐ Clinical Communication ☐ Clinical Reminders ☐ Health Awareness

I acknowledge that I may be contacted using any of the contact details I have provided.

Name:

Signature: Date:

Management of Patient Health Information

This medical centre collects information from you for the primary purpose of providing quality health care.
We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also collect, hold, use and disclose the information you provide in accordance with Nature Care Health's Privacy Policy. A copy of the Privacy Policy is available at Nature Care Health's reception.

Nature Care Health may collect, hold, use or disclose your personal information for purposes including but not limited to:

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements;
- To update our records and keep your contact details up to date;
- To communicate with you regarding appointments reminders, recalls and services which may be of interest to you;
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice;

I consent to personal information being collected, held, used and disclosed in accordance with the Nature Care Health's Privacy Policy

Signature _____ Date: _____