NEW MEDICAL PATIENT QUESTIONNAIRE

Name: Today's date:

Date of birth:

Address:

Phone number: Cell phone number:
(Can we leave messages on either or both of these phones Yes/No)

Email:

Do you give permission for Dr Pitsilis to write to your Family Doctor YES / NO

Current GP and surgery address :

Do you know your blood Group: If yes please state.

If you know your NHI number, write it here…

Do we have permission to obtain recent (6 months) blood results? YES / NO

Please mark an 'X' in front of the condition in the table below that you are concerned about

| | | | |
|---|---|---|---|
| | Migraine | | Acne |
| | Chronic pain | | Thyroid |
| | Menopause Symptoms | | Diabetes |
| | Premenstrual Syndrome | | Low Energy / Fatigue |
| | Polycystic Ovarian Syndrome | | Can't Lose Weight |
| | Endometriosis | | Irritable Bowel Syndrome |
| | Heavy / Painful Periods | | Sleep Problems |
| | Osteoporosis | | Heart Disease |
| | Memory Problems | | Blood Pressure |
| | Libido problems | | Male Potency Problems |
| | Anxiety | | Depression |
| | Stress / " Burnout" Symptoms | | |

**Are you taking the contraceptive pill?** If yes – name of pill……

**Alcoholic drinks**- what type…….. and how many per week?.....

**Have you ever smoked?** Yes/No When did you stop? ……..

How many do you smoke per day now? ……..

***DRUG ALLERGIES***

Please list any drug allergies, and what happens if you have that drug.

HEALTH PROBLEMS, OPERATIONS OR CONDITIONS - ***IN THE PAST***
(you will be listing your current concerns further down this questionnaire)

Date Age Condition / operation Any comments

……..

……..

……..

……....
.

……..

……..

***FOOD ALLERGIES***

Please list any foods, and what reaction you have to them.

PLEASE LIST ANY HEALTH PROBLEMS IN YOUR FAMILY

| | Any conditions? | Age if deceased | Cause of death |
|---|---|---|---|
| Mother | …… | | |
| | …… | | |
| Father | …… | | |
| | …… | | |
| Sisters /brothers | ……... | | |
| | ……... | | |
| | ……... | | |
| Your children | …… | | |
| | …….. | | |
| | …… | | |

***ANY HISTORY FOR YOU OR IN YOUR FAMILY OF THE FOLLOWING?***

Please circle or write **yes** if on computer, and write **which family member** it is, and any comments.

***General***

Hypertension

Heart problems

High Cholesterol

Stroke

Alzheimers disease

Parkinsons Disease

Diabetes

Asthma

Hay Fever

Food Allergies

Tonsillitis

Migraine

Irritable bowel syndrome

***Autoimmune Diseases***

Lupus

Rheumatoid Arthritis

Multiple Sclerosis

Raynauds disease

Ulcerative Colitis

Crohns Disease

Psoriasis / Psoriatic Arthritis

Ankylosing Spondylitis

Lichen Sclerosis

Coeliac disease

Myasthenia Gravis

Sarcoidosis

***Cancer***

Bowel

Breast

Ovary

Prostate

Lungs

Skin – melanoma, Basal Cell Carcinoma, Squamous cell carcinoma

***MEDICATIONS AND SUPPLEMENTS***

Please list below and write how many per day

**PLEASE BRING TO THE CONSULTATION, ALL YOUR MEDICINES/ SUPPLEMENTS**

***LIST WHAT SORT OF EXERCISE YOU DO – how often, how long etc***

***DESCRIBE YOUR SOCIAL SITUATION***

***E.g. are you married or single? Any children and their ages? Who do you live with?***

***STRESS IN PERSONAL LIFE OR WORK***

***Any problems or stress at work? Any stress in your personal life? Please list in date order what you think has caused any stress for you.***

***PLEASE LIST & DESCRIBE YOUR SYMPTOMS AND CONCERNS <u>BELOW</u>***

**Include things in your description like :**

- **When the problem started**
- **What your symptoms and concerns are.**
- **Are the symptoms made better or worse by anything?**
- **If it is pain, where it is and how severe.**
- **Is the problem associated with any other symptoms?**
- **Anything else you have noticed about your problem**

You can insert more pages if you are writing this out by hand, otherwise, just fill in the details on the computer.

1. most important problem or symptom:

2. second most important problem or symptom……..

3. third most important problem or symptom……

4. fourth most important problem ……..etc

*( you can add in another page if needed, if you are handwriting this)*

***PLEASE ANSWER THE FOLLOWING QUESTIONS:***

***SLEEP***

What time do you go to bed?

Do you get off to sleep easily? If not, please state why?

Do you sleep through the night? If not, please state why?

How do you feel when you wake up? Refreshed? Tired?

***ENERGY***

Do you have any difficulty getting out of bed? If yes, describe.

How long does it take you to get going in the morning?

What is your energy level for most of the day? /10 (10 is the best)

Do you get any times when your energy is lower? If yes, when?

What does your energy do after dinner in the evening?

***MOOD***

Please estimate how happy you feel, where 10 is the happiest possible, and zero is so depressed that you don't wish to be alive.
…… /10

***ANXIETY***

Please state whether you get anxious, where 10 is the most uptight and nervous you can possibly get, and zero is very mellow, calm and relaxed.
…… /10

For women, is this related to your cycle? Yes/No

***APPETITE***

How is your appetite? Please circle one: poor, normal, increased

Do you crave sweets/ sugar or salt? If yes please describe.

***MENTAL***

Describe how your short-term memory is working. Rate it out of ……/10 ( 10 is best)

Do you have any difficulty concentrating? For example, can you stay with an activity or read something for a while? Rate it out of ……../10

How are your thinking processes – are they working?

Do you have any difficulty making decisions or solving problems?

Can you use your mind at work?

***THOUGHT CONTENT***

What sort of things do you think about?

***PERSONALITY STYLE***

Describe your personality below. Also, please circle the descriptions that suit you – below.

| | | | |
|---|---|---|---|
| perfectionist | can't say "NO" | diplomat | type A personality |
| driven | hardworking | high standards | nervous |
| calm | worries | try to please people | |

Anything else?

***WOMEN- NOW OR IN THE PAST***

Are there any mood or anxiety symptoms related to your cycle?

Do you get any symptoms of PMS?

Eg  Breast tenderness, bowel problems like wind, constipation, diarrhoea.

If you have periods, are they heavy or painful?

Do you have sex drive problems?

Do you have any acne?  Describe. Is there any relationship to your cycle, if you have one?

<u>If post menopausal,</u> any problems like hot flushes, sleep disturbance etc

***FEMALE MENOPAUSE***

Please circle any of the following symptoms:

| | | |
|---|---|---|
| Hot Flushes | Light headed feelings | Headaches |
| Irritability | Depression | Unloved feelings |
| Anxiety | Mood Changes | Sleeplessness |
| Unusual tiredness | Backache | Joint Pains |
| Muscle Pains | Crawling feelings under the skin | Dry Skin |
| Less Sexual Feelings | Urinary Frequency | Dry Vagina |
| New Facial Hair | Uncomfortable intercourse | |

Any other comments

***MEN***

Do you have any problems passing urine?

Do you have any problems related to sex drive?

Do you have any erection problems?

***MALE MENOPAUSE***

Please circle any of the following symptoms:

Fatigue or reduction in vitality

Reduction of optimism

Reduced drive/ ambition

Reduced Libido

Depression / ‘negative ‘ or Low mood

Irritability

Aches and Pains

Sweating and hot flushes

Reduced sexual performance

Loss of fitness

Feeling overstressed

Reduced confidence

Reduced happiness

General deterioration of physical condition

Reduced stamina

Dry skin