Dr Peter Lewis
CONFIDENTIAL PATIENT QUESTIONNAIRE

Please complete the following questionnaire. Your response remains confidential and will provide information to be used 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.)	Private Health Fund	
Nationality		Occupation	
Email Address			
Height (cm)	Weight (kg)		
Next of Kin	Relationship	Telephone No:	
How did you hear about Dr Lewis?			

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?

What kind of treatment(s) have you tried for the problem(s) listed above? *Please detail any relevant testing or investigations and bring relevant copies with you to your consultation.*

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 / NO	YES / NO
Blood disorder	YES / NO	YES / NO
High blood pressure	YES / NO	YES / NO
Cancer	YES / NO	YES / NO
Arthritis	YES / NO	YES / NO

Diabetes	YES / NO	YES / NO
Liver disease / hepatitis	YES / NO	YES / NO
Kidney disease	YES / NO	YES / NO
Asthma	YES / NO	YES / NO
Epilepsy	YES / NO	YES / NO
Glandular fever	YES / NO	YES / NO
Gastroenteritis	YES / NO	YES / NO
Mental health conditions *(Please specify)*	YES / NO	YES / NO
Sexually transmitted infections *(Please specify)*	YES / NO	YES / NO
Other conditions *(Please specify)*	YES / NO	YES / NO
Operations *(Please specify)*	YES / NO	YES / NO
Pregnancies	YES / NO	YES / NO
Exposure to chemicals or toxins *(Please specify)*	YES / NO	YES / NO
Amalgam fillings	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		
Cervical screening test		
Bone density		
Cholesterol		
PSA (Prostate Blood Test)		

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	
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 below.*

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**.

IMMUNISATION HISTORY Please record any immunisations you have received.

TYPE	DATE	TYPE	DATE

CURRENT SYMPTOMS

*Please tick the box to the right of any condition you are **CURRENTLY EXPERIENCING**.*

GENERAL		WEIGHT		NERVOUS SYSTEM		EYES		EARS	
Fatigue		Weight gain		Headaches		Watery/itchy		Itchy	
Apathy/lethargy		Difficulty losing weight		Migraines		Painful/red		Ear aches	
Hyperactivity		Fluid retention		Faintness		Sticky eyelids		Infections	
Poor appetite		Binge eating		Dizziness		Blurred vision		Discharge	
Hypoglycaemia		Compulsive eating		Numbness		Deteriorating vision		Tinnitus (ringing)	
Poor sleep/insomnia		Craving for certain foods		Tingling, pins & needles		Dry eyes		Hearing loss	
Sleep apnoea		Weight loss		Poor co-ordination					
Excessive thirst		Eating disorders		Feel cold easily					
Stress				Cold hands & feet					
Easy bruising									

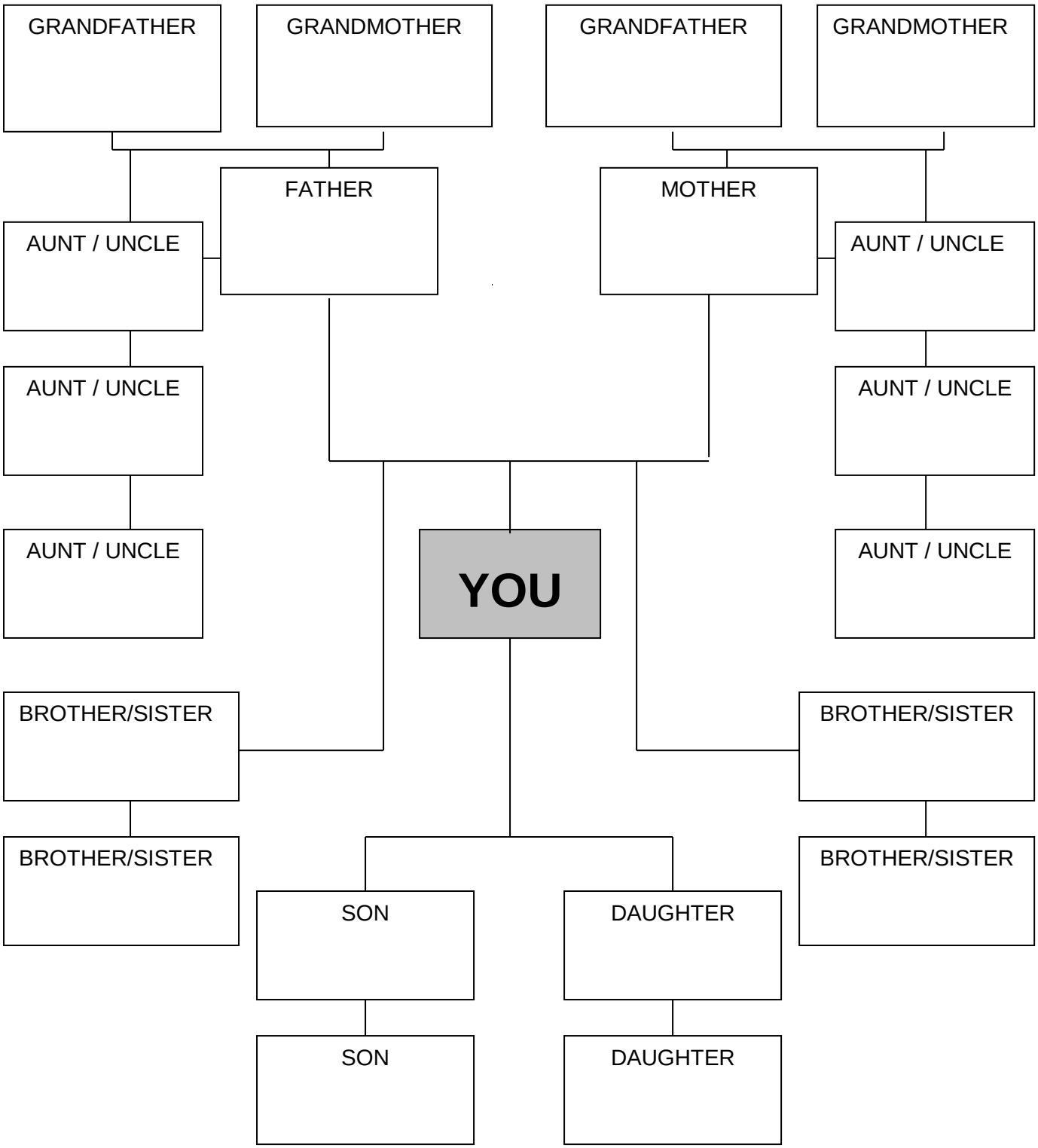
DIGESTIVE SYSTEM		HEART/CIRCULATION		LUNGS		GYNAECOLOGICAL		GENITO-URINARY	
Indigestion		High blood pressure		Shortness of breath		PMT (premenstrual)		Frequent urination	
Heartburn/reflux		Low blood pressure		Cough		Breast pain		Passing large amounts of urine	
Bloating		High cholesterol		Sputum		Breast lumps		Burning / discomfort on urination	
Feel full easily		Chest pain		Blood		Breast implants		Discharge	
Burping		Palpitations/arrhythmia		Chest tightness		Regular periods		Blood in urine	
Flatulence		Swelling of ankles		Wheeze		Irregular periods		Urgent urination	
Abdominal/stomach pains or cramps		Poor circulation				No periods		Kidney pain	
Nausea		Calf pain with exercise				Heavy periods		Difficulty passing urine	
Vomiting		Varicose veins				Menstrual clots		Passing urine frequently at night	
Difficulty swallowing						Period pain/cramps		Incontinence	
Diarrhoea						Painful intercourse		Loss of libido	
Constipation						Vaginal irritation/soreness		Erectile dysfunction (impotence)	
Piles (haemorrhoids)						Vaginal discharge			
Mucus						Thrush			
Rectal bleeding						Menopausal			
Anal itching						Hot flushes			
						Sweats			
						Vaginal dryness			
						Irregular bleeding/spotting between periods			
						Post coital bleeding			

NOSE		MOUTH / THROAT		SKIN		HAIR / NAILS		JOINTS / MUSCLES	
Congested/blocked		Mouth ulcers		Acne/pimples		HAIR		Pain	
Poor sense of smell		Cold sores		Eczema/dermatitis		Dry Hair		Swelling	
Sinus problems		Cracks at corner of mouth		Psoriasis		Increased hair loss		Stiffness	
Hay fever/allergy		Sore throat		Rosacea				Arthritis	
Sneezing		Hoarseness, loss of voice		Rashes		NAILS		Neck problems	
Excessive mucus		Gum disease/bleeding		Hives/urticaria		Soft		Back problems	
Post-nasal drip		Feeling of lump in throat		Dry skin		Break easily		Cramps / spasms	
		Loss of taste sensation		Poor healing		White spots		Muscle twitching	
		Bad breath		Excessive sweating		Ridged		Muscle tension	
				Body odour		Fungal infections		Muscle weakness	
				Dandruff				Gout	

EMOTIONS		MIND	
Anxiety		Poor memory	
Depression		Poor concentration	
Mood swings		Confusion	
Panic attacks		Poor comprehension	
Anger, irritability		'Brain fog'	

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



General Acknowledgement and Consent Form

I understand that some of the diagnostic tests, treatments and products administered by Dr Peter Lewis may be outside the parameters of conventional medicine in Australia. They fall into the category of integrative 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 Lewis are not covered by Medicare or private health insurance funds.

I am attending a consultation with Dr Lewis 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 Lewis 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 Lewis 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:

Mangement 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 IPN Medical Centre's Privacy Policy (the Centre's Privacy Policy). A copy of the Centre's Privacy Policy is available at the Centre's reception or can be obtained at the IPN's website (https://www.ipn.com.au/about/privacy-policy.html)

The Centre may collect, hold, use or disclose your personal information for purposes including but not limited to:

- Patient Satisfaction Surveys;
- 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;
- Health service promotions including important health messages;
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice;
- De-identified disclosure for research and quality assurance activities to improve individual and community health care and practice management

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

Signature _____ Date: _____