Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY

Allergy or skin disorder

Arthritis/orthopaedic conditions

Bladder or kidney problems

Bowel problems

Cancer

Circulation problems/DVT

High or low blood pressure

Heart problems or stroke/TIA

Diabetes

Raised cholesterol

Digestion/food intolerances

Epilepsy/blackouts

Dizziness or tinnitus

Liver problems

Headaches/migraines

Anxiety or depression

Broken bones

What brings you here today?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MEDICAL HISTORY

Arthritis/orthopaedic conditions

Bladder or kidney problems

Bowel problems

Cancer

Circulation problems/DVT

High or low blood pressure

Heart problems or stroke

Diabetes

Raised cholesterol

Epilepsy/blackouts

Dizziness or tinnitus

Liver problems

Headaches/migraines

LIFESTYLE

Do you smoke

Do you drink alcohol

Do you drink caffeinated drinks

Have you ever used recreational drugs

Do you take any food supplements

Do you sleep well

Do you have regular dental check ups

Do you exercise regularly

Do you have any dietary restrictions

Any recent falls or accidents

Do you have memorable or vivid dreams

Any recent:

Changes in weight (gain or loss)

Heavy sweating in the night

Bowel or bladder change

Pain in the night