



DATE: _____

PATIENT PROFILE

SURNAME: _____ GIVEN NAMES: _____

ADDRESS: _____

POSTCODE: _____

TELEPHONE (Home): _____ (Work): _____ (Mob): _____

EMAIL: _____ OCCUPATION: _____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____

MEDICARE NUMBER: _____ EXPIRY DATE: _____ REF: _____

HEALTH INSURANCE FUND: _____ MEMBERSHIP NO: _____

VETERANS AFFAIRS NO: _____ PENSIONER: YES NO

CONTACT INFORMATION

NEXT OF KIN

Name: _____ Relationship: _____

Address: _____

Telephone (Home): _____ (Work/Mob): _____

ADDITIONAL CONTACT

Name: _____ Relationship: _____

Address: _____

Telephone (Home): _____ (Work/Mob): _____

GP INFORMATION

LOCAL DOCTOR: _____ TELEPHONE: _____

ADDRESS: _____

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SPECIALIST PHYSICIAN/SURGEON: _____ TELEPHONE: _____

WEIGHT LOSS HISTORY

PLEASE DOCUMENT PREVIOUS WEIGHT LOSS ATTEMPTS (EG: *Weight Watchers, Jenny Craig, Fad Diets, Hypnotherapy, Appetite Suppressants, including any Weight Loss Surgery*)

1. _____ Duration: _____ KG Lost: _____
2. _____ Duration: _____ KG Lost: _____
3. _____ Duration: _____ KG Lost: _____
4. _____ Duration: _____ KG Lost: _____
5. _____ Duration: _____ KG Lost: _____
6. _____ Duration: _____ KG Lost: _____

LIFESTYLE INFORMATION

ALCOHOL INTAKE (*standard drinks per week*): _____ **CHOICE OF ALCOHOLIC DRINK:** _____

CIGARRETES

- SMOKER (_____/Day) EX-SMOKER (How Many Years: _____ Stopped: _____) NEVER SMOKED

CURRENT DEDICATED EXERCISE

0 Days/Week	1-2 Days/Week	2-4 Days/Week	4-7 Days/Week	(circle one)	
Walking/Running	Cycling	Swimming	Yoga/Pilates	Gym/Trainer	Other (circle one)

SLEEP PATTERNS

- | | | | | |
|----------------------------|---------|---------|-----------|--------------|
| a) I consider my sleep is: | Good | Fair | Poor | (circle one) |
| b) I usually sleep: | 6-8 hrs | 4-6 hrs | >4 hrs | (circle one) |
| c) I have sleep problems: | Yes | No | Sometimes | (circle one) |

SURGICAL HISTORY

PLEASE GIVE DETAILS OF PAST OPERATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____

WOMEN'S HEALTH

A. Do you have regular periods (26-33 days)? Yes No

If no, please provide further details _____

B. Do you have problems with heavy periods? Yes No

If yes, please provide further details _____

C. Have you had difficulty conceiving in the past? Yes No

D. Do you currently have problems with infertility? Yes No

E. Have you suffered from excess body hair or acne? Yes No

F. Have you been diagnosed with polycystic ovaries? Yes No

MEDICATIONS

Please provide details-name and length of use-of any medication you are currently on, or have previously been on, for any of the following: psychiatric disorders, migraines, weight loss, epilepsy, asthma or breathing, or hormones (e.g. Pill, HRT, Cortizone).

CURRENTLY: _____

PREVIOUSLY: _____

GASTRO-OESOPHAGEAL REFLUX/INDIGESTION

1. Do you have a history of heartburn or indigestion? Yes No *(circle one)*
2. How often do you experience reflux (e.g., daily, most days, occasionally)? _____
3. How often do you experience indigestion/heartburn during the night? _____
4. What causes/aggravates your reflux? _____
5. What treatments do you use to relieve your reflux, heartburn, or indigestion? _____
6. Do you have difficulty swallowing? Yes No *(circle one)*
7. Does food ever get stuck when you swallow? Yes No
8. Does food or fluid reflux back into your mouth? Yes No
9. Do you vomit when you experience reflux? Yes No
10. Do you suffer from recurrent sore throats? Yes No
11. Do you suffer from a hoarse voice? Yes No
12. Do you suffer from a regular evening cough? Yes No

If you answered yes to any of the above, please provide details: _____

MEDICAL ASSESSMENT

WEIGHT: _____ KG HEIGHT: _____ CM BMI: _____ NECK: _____ CM
WAIST: _____ CM HIP: _____ CM BLOOD PRESSURE: _____ / _____ MM/HG
HIGHEST ADULT WEIGHT: _____ KG LOWEST ADULT WEIGHT: _____ KG IDEAL WEIGHT: _____ KG

MEDICAL HISTORY

Have you suffered with any of the following? *(Please circle one and provide relevant details below)*

- | | | |
|-----------------------------------|-----|----|
| 1. DIABETES *NB* | Yes | No |
| 2. Diabetes whilst pregnant | Yes | No |
| 3. Asthma | Yes | No |
| 4. Respiratory/breathing problems | Yes | No |
| 5. Arthritis or joint pain | Yes | No |
| 6. Back pain | Yes | No |
| 7. Kidney or urinary disorder | Yes | No |
| 8. Neurological problems | Yes | No |
| 9. Psychological disorders | Yes | No |
| 10. Gallstones | Yes | No |
| 11. Gastric/duodenal ulcer | Yes | No |
| 12. Hepatitis or liver disease | Yes | No |
| 13. High blood pressure | Yes | No |
| 14. Heart disease | Yes | No |
| 15. High cholesterol | Yes | No |
| 16. Anaemia/bleeding disorder | Yes | No |

