Beach Street Centre

Your Health & Wellness Clinic

DR LILY TOMAS

35 Beach Street Merimbula NSW 2548

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Confidential Patient Questionnaire - Female

By accurately and in detail completing this questionnaire I can make more efficient use of your therapy session. Thank you for your time in filling out the new patient questionnaire. You can leave out any questions if you wish, or write more if you feel there is any other relevant information you need add.

Name:	DOB
Address	
Home Phone:	Mobile:
e:Mail	
Medicare Number:	Private Health Fund:No:
Medicare No. (if on a Care Plan)	
Height:	Weight
Today's Date:	

Please list your main problem (s) and reasons for this for this appointment:

What do you believe the problem(s) may be due to:
What treatments have you tried to help the problem(s):
When was the last time you truly felt well?
Do you have any known drug or other allergies?

Current Medications (Prescription/Non-Prescription)	Dosage

Nutritional Supplements (Vitamins/Minerals/Herbal/Homeopathic	Dosage

When did you last have the following tests?

	Date	Result
Mammogram or Breast Ultrasound		
Pap Smear		
Bone Mineral Density		
Cholesterol		
Prostrate Test		

List Any Other Significant Tests		

Dietary History

Do you follow a specific diet? If so, specify	Yes/No	
Do you have any know food allergies? Please list.	Yes/No	
Do you crave any particular foods? Please list.	Yes/No	
Do you avoid any particular foods? Please list.	Yes/No	

Please list any relevant family history

Medical and Surgical History

Do you suffer with or have you suffered with any of the following conditions? Please be more specific in the space provided.

Heart Disease	Yes/No	
High Blood Pressure	Yes/No	
Blood Disorders	Yes/No	
Cancer	Yes/No	
Arthritis	Yes/No	
Diabetes	Yes/No	
Liver Disease	Yes/No	
Kidney Disease	Yes/No	
Thyroid Disease	Yes/No	
Asthma/Other Respiratory Disease	Yes/No	
Neurological Disease	Yes/No	
Gastrointestinal/ Bowel Problems	Yes/No	
Chemical/Toxic Exposure	Yes/No	
Amalgam Fillings	Yes/No	
Frequent Antibiotics	Yes/No	
Other: Please List	Yes/No	

Do you Smoke? Yes/No How Much?	Do you Drink? Yes/No How Much?

Please list any operations you may have had?

Gastrointestinal Questions		
Do you experience any of the following?		
Constipation	Yes	No
Diarrhoea	Yes	No
Abdominal Bloating	Yes	No
Excess Flatulence	Yes	No
Excess Burping	Yes	No
Reflux	Yes	No
Indigestion	Yes	No
Abdominal Pain/Discomfort	Yes	No

What do you usually eat or drink:

Breakfast	
Morning Tea	
Lunch	
Afternoon Tea	
Dinner	
Dessert	
Other Snacks	

Do you experience?

Eyelid Twitches	Yes	No
Heart Palpitations	Yes	No
Feelings of Tightness	Yes	No
Restlessness/Restless Legs	Yes	No
Chocolate Cravings	Yes	No

Female Hormones		
At what age did you start to menstruate?		
Are you pregnant at the moment	Yes	No

Do you presently have periods?	Yes		No (Skip to next table)
Are your periods regular?	Yes		No
How long do they last			
Are they (circle)	Light	Medium	Heavy
Do you pass clots?	Yes		No
Do you pass old blood/dark discharges any time in your cycle	Yes		No
Do you suffer:			
Mood changes	Yes		No
Breast tenderness	Yes		No
Headaches	Yes		No
Sinus Problems	Yes		No
Other (List):			
How many days PMT do you suffer?			

If you are not having periods do you experience?		
Hot Flushes	Yes	No
Night Sweats	Yes	No
Palpitations	Yes	No
Insomnia	Yes	No
Mood Changes	Yes	No
Loss of Libido	Yes	No
Lack of Energy		

Is there any Family History of Breast Cancer?	Yes	No
Is there any Family History of Ovarian Cancer?	Yes	No
Is there any Family History of Osteoporosis?	Yes	No

CONSENT FORM

I understand that some of the diagnoses and treatments administered by Dr Lily Tomas may be outside the parameters of conventional medicine in Australia.
I understand that these diagnosis and treatments are supported by empirical knowledge, are used widely and successfully by practioners of integrative/ complementary medicine in Australia and overseas and, are only prescribed by the practitioner with utmost care.
I am attending this clinic of my own free will and consent and exercise my rights to discuss and choose any useful and suitable treatment(s) available to me.

Signed:_____Witness_____Date:_____