DR GrantFourie
GENERAL PRACTITIONER | SPECIAL INTEREST IN
FUNCTIONAL MEDICINE

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Welcome to our Practice. Please complete this form in as much detail as possible.

Medical History: First Visit Form

Patient Information **Date of consult:**

Name & Surname:			Title:	Relationship status:
ID:	Age:		Gender:	
Cell:		Email:		
Residential Address:				
Referred by:				

1. Why are you here? (Just the top 4 reasons)

	Duration		Duration
1.		3.	
2.		4.	

2. Main symptoms or complaints. Not diagnosis! indicate how long each has been a problem.

1.1	duration	1.5	duration
1.2	duration	1.6	duration
1.3	duration	1.7	duration
1.4	duration	1.8	duration

3. Previous Diagnosis. Existing medical conditions. Please indicate how long each has been a problem.

1.1	duration	1.5	duration
1.2	duration	1.6	duration
1.3	duration	1.7	duration
1.4	duration	1.8	duration

4. Previous surgery and age at time of surgery (incl. cosmetic, orthopaedic, dental, childhood, minor or post-trauma)

2.1	age	2.4	age
2.2	age	2.5	age
2.3	age	2.6	age

Have you ever been admitted to hospital for any other reason? Please give details and doctors involved (includes Psychiatric or Rehab)

Have you ever been treated for a tick bite or a spider bite or any other parasite infection? If yes, please give details. Y | N

continue...

Current medication: Please specify dosage and indicate how long you have used this

3.1	dosage/duration	3.6	dosage/duration
3.2	dosage/duration	3.7	dosage/duration
3.3	dosage/duration	3.8	dosage/duration
3.4	dosage/duration	3.9	dosage/duration
3.5	dosage/duration	3.10	dosage/duration

5. Allergies

Reactions to medications

Environmental or food allergies (eg.hayfever, metal sensitivity to jewelry, etc.)

6. Supplements

Do you use any supplements, homeopathic remedies, and/or natural products? Please specify.

Discontinued or changed supplements or medications due to negative reactions

7. Dental history

Number of metal fillings and/or crowns		Have you had any removed?	
Any braces or retainers still present?		Do you use a bite plate or grind your teeth?	
Other dental issues, please specify			

8. Conditions

Have you ever been diagnosed with, or suspected of having, any of the following? Please mark with an "X."

Anxiety		Arthritis		Asthma		Cancer		Cardiac disease	
Cholesterol		Chronic fatigue		Circulatory disorder		Depression		Diabetes	
Eczema		Epilepsy		Fibromyalgia		Gout		Hepatitis	
HIV		Hypertension		Kidney stones		Malaria		Migraine	
Renal disease		Spastic colon		Psoriasis		Thyroid		Tick bite fever	
Gallstones		Headaches		Hay fever		Porphyria		Diverticulitis	
Crohn's		Ulcerative colitis		Lung disease		COPD		Other	
If other, please specify:									

9. Family history

Please list any medical problems and/or cause of death of the following family members.

Father	alive	deceased	age	
Mother	alive	deceased	age	
Sibling	alive	deceased	age	
Sibling	alive	deceased	age	
Sibling	alive	deceased	age	

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10. Work

What do you currently do?			
Where have you worked in the past?			
How many hours a week do you work?		How many hours do you spend in traffic per week?	
Do you like what you do?			

11. Body composition: Please complete if known.

Current weight	kg	Best weight ever	kg	Desired weight	kg	Heaviest weight	kg
Height	m	Waist	cm	Hip	cm	Ratio Waist: Hip	
Weight gain or loss in last 5 years		Reason					

12. Habits and Diet:

Smoker	**Ex**	**Current**	**Never**	**How many per day?**		**How many years?**		**When last?**	
Alcohol	**Type and rough estimate of amount per week**								
	Previously drank more	**Y**	**N**	**Why the change?**					
Exercise	**Type?**					**Frequency?**			
	How do you feel after exercise?								
Regular Hobbies	**Include bee keeping / horse riding / Small home animals / hiking or other exposure to outdoor and nature areas**								
Social	**Marital status**		**Kids at home**		**Previously divorced**	**Y**	**N**		
Diet	**Do you follow a specific type of diet programme? eg. Banting, Paleo, Weight Watchers, etc.**								
Fluid	**Daily intake of Water**		**What else do you drink?**						
	Please indicate how many of these you consume per day :								
	Coffee		**Tea**		**Sugars**		**Energy drinks (e.g. Red Bull)**		**Type of sweetener**
Sleep	**Quality**		**Number of hours**						
	Average bedtime?		**Average wake time?**		**Do you feel refreshed in the morning?**				
	Do you experience any of the following? Please mark with an "X."								
	Struggle to fall asleep		**Must use sleeping tablet**		**Wake in early hours, can't sleep**		**Snore**		**Stop breathing**
Religion	**Spiritual / Religious affiliations?**								
Narcotic Use	**Previous use of any drugs or hallucinogens?**	**Y**	**N**	**If yes, please mark with an "X"**					
	Mushrooms	**Ayahuasca**	**Ibogaine**	**LSD**	**MDMA**	**Dagga**	**OTHER**		
	Previous rehab admission for addictions?								
Pets	**What pets do you keep?**								

13. Body systems: Do you experience any of the following? Please mark with an "X".

Mood:											
Happy		Anxious		Obsessive		Aggressive		Irritable		Depressed	
Energy:											
Permanent fatigue		Fluctuates		Afternoon dips		Morning tiredness		Dips a few hours after exercise		Plenty	
Abdominal:											
Cramping		Diarrhoea		Constipation		Heartburn		Ulcers		Hiatus hernia	
Colonoscopy		Gastroscopy		Previous surgery		Bloating		Feel full quickly		Burping	
Hemorrhoids		Spastic colon		IBS		SIBO		H. Pylori		Bleeding top or bottom	
Heart:											
Chest pain		Palpitations		Angina		Irregular heart rate		Previous angiogram		Heart murmurs	
Heart failure		Fluid retention		Short of breath quickly		High blood pressure		Low blood pressure		Cholesterol meds	
Lungs:											
Short of breath		Cough		Asthma		Emphysema		Still smoking		Fingers go blue	
Joints and muscles:											
Aches and pains		Cramping		Stiffness		Weakness		Joint pain		Back pain	
Nerves:											
Weakness		Pins and needles		Burning feet		Shooting pains		Ataxia/Off-balance		Tremor	
Bladder:											
Incontinence		Leak if sneeze		Frequent infection		Get up at night		Urgency if need to go		Weak stream	
Gynae:											
Last visit to gynae	20	Last pap smear	20	Last mammogram	20	Last sonar	20	Cancer		Oestrogen sensitive	
Immune system:											
Get sick easily		Slow to heal or recover		Frequent antibiotics		Antihistamines		Cortisone		Chemotherapy	
Hormones:											
Fatigue		Feel hot		Always cold		Sweat a lot		Sweat too little		Hot flushes	
Crave salt/sugar or chocolate		Afternoon energy dips		Poor sleep		Swelling in neck		Cold hands or feet		Poor circulation	
Psychology:											
Depression		Bipolar		Anxiety		Schizophrenia		Previous self-harm		Addiction history	
Skin:											
Dry		Oily		Scaly		Excema/Psoriasis		Allergy/Rashes		Abscesses/Acne	
Eyes/Ears/Nose/Throat:											
Spectacles		Contacts		Glaucoma		Dryness of eyes		Sinusitis/ Postnasal drip		Dizziness	
Allergies		Vertigo/Dizziness		Polyps		Deafness		Lump in throat		Thyroid	
Other:											

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MALE PATIENTS ONLY

Do you experience any of the following? Please mark with an "X".					
Problems with erection or sensation		Problems with ejaculation		Low libido	
How long have these been a problem?					
Do you experience any of the following? Please mark with an "X".					

Tendency to procrastinate		Increase in anxiety levels		Grumpy		Anti-social	
Snoring/Sleep apnoea		Fall asleep in front of TV		Fatigue		Urinate more at night	
Must run if bladder full		Urine pressure low / Have to wait for flow					

FEMALE PATIENTS ONLY

14. Gynae history

13.1 Pregnancies	Ectopic		Miscarriage		No. of living children		Children's ages	
	Normal deliveries		Caesarians		Fertility treatment			
	Difficulty falling pregnant	Y/N	Medical conditions during or after pregnancy					
	Weight gain that couldn't be lost		Breastfed babies	Y/N				
	Depression after pregnancy							
13.2 Contraceptive	Current		Sterilised	Y/N	Previous			
	How did you respond to contraceptives?							
	Used for:	Contraception	Y/N	Skin / Acne	Y/N	Period control	Y/N	Total years on contraceptive?
13.3 Period history	No. of bleeding days		Average length of cycle		Last normal period			
	How are/were your periods *without* contraceptive? Please mark with an "X".							
	Regular	Irregular	Heavy	Light	Short	Long	Painful	
13.4 Period symptoms	Please rate symptoms before/during your period from 1 to 10 where 1 is "Mild" and 10 is "Severe."							
	Headaches		Breast tenderness		Moody		Bloated	
	Swelling		Irritable		Fluid retention		Sugar cravings	
13.5 Hormone therapy	Hormone Replacement Therapy (HRT)	Y/N	If "yes", please specify HRT history					
	Poly Cystic Ovarian syndrome (PCOS)		Endometriosis		Hysterectomy		Age at hysterectomy	
	Reason for hysterectomy:							

15. General symptoms: Rate from 1 to 10 where 1 is "Okay" and 10 is "Really bad."

Hot flushes		Tiredness		Poor sleep		Low libido	
Skin dry		Vaginal dryness		Hair loss/thinning		Moody	
Poor memory		Unclear thinking		Vaginal thrush		Cellulite	
Weight gain on tummy		Swelling/fluid retention		Bladder leaking		Sweating	
Hair growth on face							

DOCTOR'S SECTION (Please leave blank)

BP		HR		Temp	
JACCELL					
Skin		ENT		Dental	
KVS					
Resp					
Abdo					
Neuro					
Loco-motor		GUT			
Endocrine					
Body composition					
BMI		Body fat%			
Immune / Defense / Repair					
Assimilation					
Circulation / Transport					
Structural integrity					
Gut health					
Communication					
Energy					
Biotransformation & elimination					
Psychological					
Neurotransmitter					

DOCTOR'S SUMMARY

Community:					
Environmental:					
Intolerance:					
Psychology:					
Spiritual:					
NOTES:					
Mood:					
Happy	Sad	Despondent	Frustrated	Irritable	
Angry	Emotionally unstable	Anxious	Stressed		
Behaviour:					
Obsessive	Compulsive	Poor Focus/concentration	Bipolar	Antisocial	ADHD