DR GrantFourie
GENERAL PRACTITIONER | SPECIAL INTEREST IN
FUNCTIONAL MEDICINE

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Medical History: First Visit Form

Patient Information **Date:** dd/mm/yyyy

Name & Surname:			Title:	Mr	Mrs	Ms
Date of Birth:	Age:	Weight:	Gender:			
Residential Address:						
			Postal Code:			
Referred by:						

Welcome to our Practice. Please complete this form with as much detail as possible.
The more information I have, the better we can help you. Nothing is unimportant. Thank you!

1. Main concerns and existing 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

2. 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 reason other than surgery? Y N
If yes, please give details and doctors involved (includes Psychiatric or Rehab)

3. Current medication: Please specify dosage and duration.

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

4. Allergies

Reactions to medications

Environment or food allergies (eg. hayfever, metal sensitivity to jewellery, etc.)

5. Supplements

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

Discontinued or changed supplements or medications. Please specify why.

6. 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			

7. 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	
Excema		Epilepsy		Fibromyalgia		Gout		Hepatitis	
HIV		Hypertension		Kidney stones		Malaria		Migraine	
Renal disease		Spastic colon		Psoriasis		Thyroid		Tick bite fever	
Gallstones		Headaches		Hayfever		Porphyria		Diverticulitis	
Crohn's		Ulcerative colitis		Lung disease		COPD		Other	
If other, please specify:									

8. 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	

9. 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?			

10. 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					

continued on next page

11. Habits and Diet

11.1 Smoker	Ex		Current		Never	How many per day?		How many years?		When last?			
11.2 Alcohol	Type and rough estimate of amount per week												
	Previously drank more		Y		N	Why the change?							
11.3 Exercise													
	How do you feel after exercise?												
11.4 Social	Marital status				Kids at home			Previously divorced		Y		N	
11.5 Diet	Do you follow a specific type of diet programme? eg. Banting, Paleo, Weight Watchers, etc.												
11.6 Water	Daily intake				What else do you drink?								
	Please indicate how many of these you consume per day												
	Coffee		Tea		Sugars		Energy drinks (eg. Red Bull)		Type of sweetener				
11.7 Sleep	Quality									Number of hours			
	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		

12. 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
Previous colonoscopy		Previous gastroscopy		Previous surgery		Bloating		Feel full quickly		Burping
Heart:										
Chest pain		Palpitations		Angina		Irregular heart rate		Previous angiogram		Previous cardiac surgery
Heart failure		Fluid retention		Short of breath quickly		High blood pressure		Low blood pressure		Cholesterol medication
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		Morning tiredness
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		Sinusitus/ Post nasal drip		Dizziness
Allergies		Vertigo/Dizziness		Polyps		Deafness		Lump in throat		Thyroid
Other:										

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

13. 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	Y/N	Endometriosis	Y/N	Hysterectomy	Y/N	Age at hysterectomy						
	Reason for hysterectomy												

14. 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							

THANK YOU - I look forward to *"Walking the path to better health, with you."*

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%		BIA	
Immune / Defense / Repair					
Assimilation					
Circulation / Transport					
Structural integrity					
Gut health					
Structural integrity					
Communication					
Energy					
Biotransformation & elimination					
Psychological					
Neurotransmitter					

DOCTOR'S SUMMARY

Triggers
Antecedents
Notes