Mosman Integrative Medicine
New patient questionnaire

Date: _____ Title: _____

First Names: _____ Last Name: _____

Street: _____

Suburb: _____ State: _____

Country: _____ Postcode: _____

Phone: _____ Mobile: _____

Email: _____

Web: _____

Skype: _____ Social/other: _____

Preferred contact method: Phone SMS/Text email other _____

Tick this box if you would like to receive our newsletter?

Date of Birth: _____ Country of birth _____

Medicare #: _____ Expiry: _____

Next of kin: _____

Relationship: _____ Contact: _____

Referring practitioner details:

How did you hear about MIM:

Main Health Complaints:

Desired Goals / Outcomes:

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Allergies, intolerances and sensitivities

Classical allergy
(e.g. asthma, hay fever, eczema)

Intolerances
(e.g. lactose, gluten, sugar)

Sensitivities
(e.g. MCS, EHS, light, sound)

Toxic exposures

Chemicals
(e.g. farm, solvents, metals)

Biotoxins
(e.g. mould, air con, gut dysbiosis)

Other toxins
(e.g. workplace, radiation, poisons)

Family History of significant diseases/conditions

Mother's side

Father's side

Siblings

Children

Origins and environment

Obstetric history

Where you grew up

Current home

Current work/school

Occupation past & present

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Past Medical and Health Conditions

Childhood Diseases
(Infections, trauma, etc)

Teen/Adult Diseases
(e.g. diabetes, hypertension etc)

Past Treatments

Medications
(e.g. antibiotics, acid reglux etc)

Natural Therapies
(e.g. herbs, acupuncture etc)

Hospitalisations
(e.g. reasons and year)

Current Known Diagnoses, Diseases and Illness

Current and recent treatment / management

Prescription and other medications

Complementary Medicine (herbs, supplements etc)

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Diets - past and present

Current dietary type
(e.g. vegan, keto, Paleo , etc)

Past diets tried
(and outcomes)

Dietary components

Alcohol use
(Current, past and type)

Coffee / caffeine drinks
(Current, past and maximum)

Sugar intake
(Current, past and maximum)

Lifestyle

Travel history
incl health issues

Exercise
types, frequency, etc

Smoking history
years + number of cigs/day

Sleep habits
Av. hours, restfulness, problems

Are there stresses that worsen your illness

Past illness - specific

Cancer	Heart disease	Stroke
Diabetes	Autoimmune	Thyroid
Infection	EBV/Gland F	CFS
Antibiotic	Gut disorder	Injury
Trauma / PTSD	Mood disorders	

I understand that the information provided on this form will become part of my medical records at Mosman Integrative Medicine, and my doctor may rely on this information in clinical decisions & care

Yes, include in my medical records

No, do not include in medical records

Please save this document to your computer and email it to pm@mimpractice.com

OR

Use submit button ONLY with Acrobat