



# Breakspear Hospital

## MEDICAL QUESTIONNAIRE

Please complete all the boxes and bring the completed form to your appointment.

### Personal Details:

Today's Date  
(dd/mm/yyyy)

First Name(s)

Last Name

Address

Post Code

Phone Number

Date of Birth  
(dd/mm/yyyy)

Height

Weight

Occupation

Blood Pressure

Pulse (first thing  
before eating)

Main symptom

### Environment Details:

Yes

No

Yes

No

Yes

No

Do you live in the country?



Are there coal fires  
in your home?



Do you smoke?



Is there gas in your home?



Do you live near  
a main road?



Are there any smokers  
in the family?



Where do you shop?

### Tick the boxes of those which have occurred regularly over the past year

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Overweight          | <input type="checkbox"/> Cold                              | <input type="checkbox"/> Forgetfulness                     |
| <input type="checkbox"/> Underweight         | <input type="checkbox"/> Hot                               | <input type="checkbox"/> Depression                        |
| <input type="checkbox"/> Fluctuating weight  | <input type="checkbox"/> Sweating                          | <input type="checkbox"/> Anxiety state                     |
| <input type="checkbox"/> Skin: itching       | <input type="checkbox"/> Pulse: fast                       | <input type="checkbox"/> Irritability                      |
| <input type="checkbox"/> burning             | <input type="checkbox"/> slow                              | <input type="checkbox"/> Aggressiveness                    |
| <input type="checkbox"/> eczema              | <input type="checkbox"/> Breathlessness                    | <input type="checkbox"/> Cannot miss or be late for a meal |
| <input type="checkbox"/> urticaria           | <input type="checkbox"/> Frequent urination                | <input type="checkbox"/> Obsessional eating                |
| <input type="checkbox"/> itching scalp       | <input type="checkbox"/> Water retention                   | <input type="checkbox"/> Eating for comfort                |
| <input type="checkbox"/> dandruff            | <input type="checkbox"/> Dark puffy circles under the eyes | <input type="checkbox"/> Craving a specific food           |
| <input type="checkbox"/> Abdominal cramps    | <input type="checkbox"/> Aching: muscles                   | <input type="checkbox"/> Poor appetite                     |
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> joints                            | <input type="checkbox"/> High blood pressure               |
| <input type="checkbox"/> Diarrhoea           | <input type="checkbox"/> back                              | <input type="checkbox"/> Low blood pressure                |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Fibrositis                        | <input type="checkbox"/> Were you ever bottle fed?         |
| <input type="checkbox"/> Bloating after meal | <input type="checkbox"/> Fatigue for no reason             |  |
| <input type="checkbox"/> Flatulence          | <input type="checkbox"/> Drowsiness                        | When are you worse:  |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> especially after meals            | <input type="checkbox"/> Spring                            |
| <input type="checkbox"/> Weeping eyes        | <input type="checkbox"/> Waking up tired                   | <input type="checkbox"/> Summer                            |
| <input type="checkbox"/> Itching eyes        | <input type="checkbox"/> Clumsiness                        | <input type="checkbox"/> Autumn                            |
| <input type="checkbox"/> Visual problems     | <input type="checkbox"/> Floating feeling                  | <input type="checkbox"/> Winter                            |
| <input type="checkbox"/> Sneezing            | <input type="checkbox"/> Tenseness                         | <input type="checkbox"/> At home                           |
| <input type="checkbox"/> Sinusitis           | <input type="checkbox"/> Headaches (tension)               | <input type="checkbox"/> At work                           |
| <input type="checkbox"/> Itching nose        | <input type="checkbox"/> Nervousness                       | <input type="checkbox"/> On holiday                        |
| <input type="checkbox"/> Runny nose          | <input type="checkbox"/> Insomnia                          | <input type="checkbox"/> First thing in the morning        |
| <input type="checkbox"/> Post-nasal drip     | <input type="checkbox"/> Waking during night               | <input type="checkbox"/> Day time                          |
| <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Hypoactive                        | <input type="checkbox"/> Night time                        |
| <input type="checkbox"/> Hoarseness          | <input type="checkbox"/> Hyperactive                       | <input type="checkbox"/> Before meals                      |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Hysterical                        | <input type="checkbox"/> After meals                       |
| <input type="checkbox"/> Catarrh             | <input type="checkbox"/> Mental confusion                  | <input type="checkbox"/> After shopping                    |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Mouth ulcers                      | <input type="checkbox"/> In heavy traffic                  |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Tingling lips                     | <input type="checkbox"/> All the time                      |
| <input type="checkbox"/> Ears: ringing       | <input type="checkbox"/> Cramp                             |  |
| <input type="checkbox"/> aching              | <input type="checkbox"/> Inability to concentrate          | <input type="checkbox"/> Have you ever taken<br>cortisone? |

### - WOMEN ONLY -

- Menopause
- Menstrual cycle:
- Regular
- Irregular
- Amenorrhoea
- Painful
- Cysts:
- Breast
- Ovarian
- Toxaemia of pregnancy
- Contraceptive pill Dates:
- Pregnancy Dates:
- Miscarriage Dates:

**Operations (list with dates)**

**Brief history of past illnesses (other than normal childhood)**

**Family history**

**What drugs/medicines are you taking now?**

**Diagnosis**

- |   |   |
|---|---|
| <input type="checkbox"/> Migraine           | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Myxoedema          | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Schizophrenia        |
| <input type="checkbox"/> Agoraphobia        | <input type="checkbox"/> Thyrotoxicosis       |

**Other illness(es)**

**List of known allergies (including drugs)**

**Do you agree to having your doctor notified?**

- Yes  No

**Name of your doctor**

**Address**

**Phone No**

**How often, if at all, do you consume the following:**

	Never	Infrequently	Sometimes	Regularly/daily	Frequently
bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcoholic drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sugar (cane) brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oranges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
corn and corn products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pork/bacon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
preserved meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cakes or biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
beetroot or beet sugar (white)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cereals/breakfast foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lamb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
root vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer the following**

	Yes	No	
Is there any food that you eat at least once a day (or crave for)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please list</i>
Do you eat regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<i>How many times per day do you eat?</i>
Is there any food you dislike?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please list</i>
Is there any food that you avoid because it disagrees with you?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please list</i>
Do you eat out?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, how often?</i>
When you were a child were there any foods you disliked, or felt ill after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, please list</i>
Since your symptoms started, have you increased your intake of any food?	<input type="checkbox"/>	<input type="checkbox"/>	
Do traffic fumes upset you?	<input type="checkbox"/>	<input type="checkbox"/>	
Do crop sprays or pesticides affect you?	<input type="checkbox"/>	<input type="checkbox"/>	
Do gas fumes upset you?	<input type="checkbox"/>	<input type="checkbox"/>	
Do enclosed shopping areas affect you?	<input type="checkbox"/>	<input type="checkbox"/>	

**Describe a typical day's diet**

Breakfast	Tea	Snacks/Other foods
Lunch	Dinner	