



PATIENT REGISTRATION FORM AND QUESTIONNAIRE

PERSONAL DETAILS

First appointment date: ___ / ___ / ___

Surname:

Forenames:

Title: Mr /Mrs /Ms /Miss/Other

Date of birth: ___ / ___ / ___

Address:

Postcode:

Telephone (H):

(Mobile):

E-mail:

Occupation:

Who recommended you to see Dr Daya:

Next of Kin:

Contact Number:

GENERAL PRACTITIONER

Name:

Surgery Address:

We sometimes use test results from our patients in our research programme and when we do, this is in a completely anonymous way. It helps us make treatment advances in the work we are doing. Do you object to the anonymous use of your tests results for research purposes?

No, I do not object €

Yes, I do object €

Complementary medicine treatments are not as evidence based, or as well researched as conventional treatments, largely because they are non-patentable.

Some of our diagnostic techniques are also not as well researched as conventional diagnostic methods.

I have read and understand these statements.

Signed:

Date:

Patient's name: _____

HISTORY OF CURRENT PROBLEM

Please list in order of importance the reason you are attending the clinic. Please do not feel that you have to limit yourself to one complaint. Please mention all your significant symptoms, as there may be a relationship between them, and state approximately the date of onset of each complaint.

Condition	Onset of condition (approx date)

Please state below medication you are currently taking:

Please state below what nutritional supplements you are currently taking:

Please state below what allergies you may have:

PAST MEDICAL HISTORY

Please list in chronological order all major diagnosis, conditions, operations, other major treatments, serious accidents or injuries, special tests, x-rays, etc.

Year and month	Condition
_____	_____
_____	_____
_____	_____

Have you had chemotherapy / radiotherapy?

To your knowledge, have you been in contact with any toxic substances (e.g. weed killer, asbestos, organo phosphates)

Are there any other details you feel should be mentioned about your health? If YES please state:

FAMILY MEDICAL HISTORY

Is there a family history of the following conditions:

Heart Disease/High Blood Pressure	Diabetes
Thyroid Disease	Allergies
Multiple Sclerosis	Cancer

Please add below any health problems in your immediate family that have not been addressed above. In particular did any member become seriously ill or die at a young age:

GENERAL QUESTIONS

Do you sleep well? Do you sleep during the day?

How many hours sleep do you get per night?

Do you exercise? YES / NO Type of exercise:

How often?

Do you consider your weight to Normal Under Over

be:

Do you consider yourself to be under stress? What type of stress?

How many silver fillings do you currently have in your mouth? 1-2 4-6 A mouthful

Have you had any silver/amalgam fillings replaced? YES / NO When?

Do you use hair dye? YES / NO How often?

Do you know what your blood group is? O A B AB

Are you/have you been a blood donor?

Do you keep any pets? (*Please specify*)

DIETARY AND LIFESTYLE

1. Do you smoke? If YES state if cigarettes, etc. and how many per day:
2. Do you drink? If YES state daily consumption of alcohol:
3. Do you drink tea and/or coffee? If YES please complete questions below:

Cups of tea per day:

Cups of coffee per day:

Do you take sugar with your beverage? YES / NO

Do you take artificial sweeteners with your beverage? YES / NO

4. Do you or have you used drugs recreationally? YES / NO

5. What do you normally eat at the following meals:

Breakfast

Lunch

Dinner

6. State the approximate times you take your meals:

7. How much water do you drink per day?

8. Do you crave sweet foods? *If YES give details:*

Other foods? *If YES give details:*

9. How often do you eat foods containing the following: *(e.g. daily/weekly/monthly/rarely)*

Dairy	Caffeine
Wheat	Sugar
Yeast	Potatoes

10. List all foods you have avoided or have limited your intake thereof:

11. List all foods that you enjoy or crave:

SYMPTOM QUESTIONNAIRE

At present, or recently have you experienced any of the following?

Soreness/cracking at the corners of the mouth	Migraine	Palpitations
Mouth ulcers	Giddiness	Ankle swelling
Dental problems	Blackout	Depression
Sore tongue	Pins and needles	Anxiety
Indigestion	Eye problems	Insomnia
Diarrhoea	Ringing in ears	Poor memory
Constipation	Ear problems	Poor concentration
Wind	Poor hearing	Nightmares
Bloating	Repeated infections	Dream a lot
Itchy anus	Sore throat	Unable to recall dreams
Piles	Swollen glands	Sleep walking
Poor appetite	Skin rashes	Excessive thirst
Weight gain	Dry skin	Frequent urination
Weight loss	Greasy skin	Painful/burning urination
Fluctuation weight	Dandruff	Difficulty passing urine
Jumpy/restless legs	Dry hair	Fatigue
Muscle cramps	Excessive ear wax	Lack of stamina
Muscle aches	Greasy hair	Exhaustion
Stiff joints	Catarrh	Craving for sweet foods
Swollen joints	Blocked/runny nose	Watery eyes
Painful joints	Chest pains	Excessive sweating
Back pains	Phlegm/Coughing	Athletes foot
Neck pains	Cold hands or feet	Fungal skin infections
Soft brittle nails	Shortness of breath	Headaches
Hair loss, thinning	Low libido	

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE