Please ensure each question is answered. If it does not apply, write "N/A" or "Nil" accordingly.

Surname________________________________ First Name ___________________________________

Gender: Male___ Female___ Weight (kg) __________ Height (cm) __________

Date of Birth ______/______/_______ Nationality _________________________________

Home Address____

Suburb _______________________________________ State _____________ Postcode _____________

Home Ph______________________ Work Ph______________________Mobile ______________________

Email Address____

2nd Email Address (if applicable)____

Your occupation____

Name of your GP___________________________Contact Number for GP______________________

What is your blood group _________________

Blood Pressure ______ /______ Heart beats p/m ______

Medicare Number __________ ________________________ ____

Expiry Date ______/_______ Reference Number ___________________________

Are you an Aboriginal or Torres Strait Islander? Yes___ No___

Please forward previous blood test report, Hair test, Salivary test, Dexa Scans, MRI's, etc,.

Hobbies and sport ____

____

____

____

Initial _______

Please List the following:

PAST SURGERY – please list ALL surgery you have had and the YEAR it occurred

____
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PAST MEDICAL HISTORY – please list ALL medical problems you have had and the YEAR they began. Please * any work-related injuries and note if it is a workers comp claim

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ALL MEDICATIONS/NUTRIENTS – please list ALL script medications, vitamins, minerals, herbals, etc. Dosage and time taken.

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Initial _______

ALLERGIES – please list ALL allergies to medications, vitamins, minerals, herbs, food, etc.

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FAMILY HISTORY - Please indicate whether there is a history of the following conditions in your family: heart disease, high blood pressure or circulatory conditions, cancer, diabetes, osteoarthritis, ankylosing spondylitis, rheumatoid arthritis, multiple sclerosis, muscular dystrophy, mental illness, auto-immune disorders, asthma, allergies, psoriasis, eczema, alcoholism, drug abuse or any other conditions that are pertinent to your present state of health.

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Smoking and Alcohol

Do you Smoke? No___ Yes___ If Yes, How many per day? _____

Have you smoked in the past? No___ Yes___ If Yes, What year did you quit? _______________

Alcohol – how much alcohol do you drink per week on average? __________________________

____

In the past 12 months, have you had any weight loss ________kg or weight gain __________kg

Initial _______

Your Current Physical Health on a scale 0-10, where (10 highest)

What number do you believe reflects your current level of health*? ___________

On a scale of 0-10 (10 most energetic), how would you rate your energy level?* _________

What time of day is it lowest?* ___________ What time of day is it highest? *___________

Typically, how often do you exercise per week?*

☐ never ☐ once or twice ☐ every other day ☐ daily

What exercises are part of your typical routine?

____

____

Your Current Mental Health on a scale of 0-10 (10 highest)

What number do you believe reflects your current level of stress?* ________

Please list the three most significant stressful events in your life. Indicate those continuing to impact your life.*

____

____

____

What do you typically eat throughout the day?

MEAL	**Food Description and Amount**	**Time**
BREAKFAST		
MORNING TEA		
LUNCH		
AFTERNOON TEA		
DINNER		
BEFORE BED		

Initial _______

Please tick '√' the appropriate column

Topic
GENERAL

Have you had	Never	In the past	Recently	Frequently
Weight Loss _________Kg				
Weight Gain _________Kg				
Anorexia bulimia				
Fevers				
Fainting				
Sleeping difficulty				
Fatigue				
Drug issues				
Alcohol issues				
Seizures				
Cancer				
Mumps				
Chills				
Sweats				
Epilepsy				
Low blood sugar				
Hypoglycaemia				
Diabetes				
Chronic fatigue/Fibromyalgia				
Liver disease				
Other…..				

Topic
EAR, NOSE, THROAT

Have you had	Never	In the past	Recently	Frequently
Eye strain/pain				
Blurred vision				
Sensitivity to light				
Glaucoma				
Failing vision				
Tinnitus/ear noises				
Ear infections				
Hearing problems				
Sinus infections				
Sore throats				
Nose bleeds				
Nasal drainage				
Teeth grinding				
Hoarse throat				
Mouth ulcers				
Gum disease				
Other…..				

Initial ________

Topic
GENITOURINARY

Have you had	Never	In the past	Recently	Frequently
Cystitis or Kidney infection				
Prolapse				
Stones				
Frequent urination				
Night urination ______ times				
Blood in urine				
Urinary infections				
Bed wetting				
Incontinence				
Painful urination				
Sexually transmitted infections				
Pus in urine				
Thrush or Candida				
Genital infection				
Oral or genital herpes				
Other…..				

Topic
LUNGS

Have you had	Never	In the past	Recently	Frequently
Asthma or emphysema				
Pneumonia or Bronchitis				
Wheeze after viral infection or exercise				
Mycoplasma				
Tuberculosis				
Chronic cough				
Phlegm				
Coughing up blood				
Hay fever				
Pleurisy				
Chest pain				
Difficulty breathing				
Other…..				

Topic
IMMUNE SYSTEM

Have you had	Never	In the past	Recently	Frequently
Boils				
Cold sores				
Conjunctivitis				
Thrush				
Tonsillitis				
Lupus				
Glandular fever				
Ross River virus				
Shingles				
Other…..				

Initial ________

Topic
DIGESTION

Have you had	Never	In the past	Recently	Frequently
Heartburn or Reflux				
Bloating after meals				
Constipation				
Burping, Farting or wind				
Diarrhoea or loose stools				
Nausea (feeling like vomiting)				
Stomach ulcers or stomach pain				
Gall bladder problems				
Eating disorder				
Colitis				
Appendicitis				
Haemorrhoid				
Hepatitis				
Trouble swallowing				
Ulcers				
Jaundice				
Abnormal liver function tests				
Liver damage or Fatty liver				
Leaky Gut Syndrome				
Other…..				

Topic
SKIN, HAIR & NAILS

Have you had	Never	In the past	Recently	Frequently
Acne or pimples				
Brittle nails				
Dry skin				
Eczema or dermatitis				
Hair loss				
Psoriasis				
Rashes				
Sore or cracked lips				
Tinea or ringworm				
Warts				
Itching				
Increased hairiness				
Bruise easily				
Boils				
Varicose veins				
Sensitive skin				

Initial ________

Topic
CARDIOVASCULAR

Have you had	Never	In the past	Recently	Frequently
Angina or chest pain				
Cold hands and feet				
Fluid retention				
Heart attack				
Heart failure				
Heart murmur				
High blood pressure				
Palpitations or irregular heart beat				
Fast/Slow heart beat				
Blood clotting				
Ankle leg swelling				
Deep Vein Thrombosis (DVT)				
Stroke/TIA				
Pulmonary embolus				
Anaemia				
Easy bruising				
Other…..				

Topic
NERVOUS SYSTEM
MUSCLE/JOINTS

Have you had	Never	In the past	Recently	Frequently
Agitation or anxiety				
Blurred vision				
Chronic pain				
Depression				
Dizziness or vertigo				
Facial twitching				
Fidgeting or restless legs				
Fits or seizures				
Leg/foot or hand cramps				
Loss of balance				
Memory loss				
Migraine or other headache				
Mood swings or irritability				
Muscle pain				
Muscle weakness/heaviness				
Osteoporosis				
Poor concentration				
Tremor of the hands				
Ankylosing spondylitis				
Stiff neck				
Backache				
Gout				
Tendinitis				
Osteoarthritis or Rheumatoid Arthritis				
Bursitis				
Fibromyalgia				
Spinal curvature				

<u>**Topic**</u>
WOMEN ONLY

Have you had	Never	In the past	Recently	Frequently
Irregular periods				
Painful periods				
Excessive bleeding				
Endometriosis				
Ovarian Cysts				
Fibroids				
Vaginal discharge				
Breast lumps or cyst				
PMS/PMT				
Periods with cramps				
Periods with backache				
Urine fibroids				
Abdominal PAP result				
Breast pain/tenderness				
Menopausal symptoms				
Hot flashes				
Been on HRT				
Been on oral contraceptive				
Other…..				

<u>**Topic**</u>
MEN ONLY

Have you had	Never	In the past	Recently	Frequently
Poor stream				
Erection issues				
Foreskin issues				
Prostate issues				
Other…..				

<u>**Topic**</u>
ALLERGIES

Are you allergic to	No	Yes	What year	List
Medications				
Foods or herbs				
Hay fever or Sinus Trouble				
Nasal blockage				
Other…..				

<u>**Topic**</u>
ACCIDENT/INJURED

Have you been injured or in accident	No	Yes	What year	List
Car				
Plane				
Motorcycle				
Marine				
Bicycle				
Industrial				
Work				
Sporting				
Major fall or slip				
Other…..				

Initial ________

Topic
CANCER

Have you had cancer	No	Yes	What year	List
Melanoma or other skin				
Breast				
Ovary or Uterus				
Lung				
Lymphoma or Leukaemia				
Stomach or Colon				
Dysplastic Nevi				
Other…..				

What is the main condition for coming to us and what are the symptoms or problems, and what is your major goal, you want us to help you with? List the very first time you noticed the condition and describe carefully anything that you suspect may have played a role in the development.
(Please use back page 'additional comments' if more space is required).

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I hereby authorize the Institute of Cellular Biomedicine A.C.N: 169 946 052 medical team and staff to perform examinations and/or treatment deemed necessary. I declare that I am over 18 years of age and I am NOT under any sporting or professional code where the treatments or medicines offered are prohibited.

Patient Signature * ____________________________

Print Name * ____________________________ Date * ______/______/ 20____

Initial _______