INFORMATION AND PAYMENT DETAILS

CENTRE FOR Health and Wellbeing

DR ANTONIA TURNBULL & DR CATHERINE PETERSON
NaProTECHNOLOGY

PATIENT DETAILS

Mr Mast Mrs Miss Ms Dr Surname _____

Given names _____ Preferred name _____ DOB _____

Residential address _____

_____ Post Code _____

Mailing address _____

Phone mobile _____ home _____ work _____

Email _____ Occupation _____

PLEASE SHOW YOUR CARDS TO RECEPTIONIST

Medicare number _____ Ref #_____ Expiry date _____

Pension card / Health care number _____ Expiry date _____

Veteran's Affairs Gold Card _____ Expiry date _____

Name of next of kin NOK _____ Relationship of NOK_____ Phone _____

Emergency contact name (if different) _____ Phone _____

Do you have any Private Health Cover (please circle) Yes No Name of fund _____

Do you identify yourself as Aboriginal and / or Torres Strait Islander origin? (please circle) Yes No Both

Do you identify with any other cultural group? _____

Do you have any allergies? (please circle) Yes No

If yes, please list _____

How did you hear about this service? _____

The Privacy Act 1988 governs the way your personal information is collected, stored, monitored and disclosed: safeguarding its integrity and confidentiality. Your privacy is important to us. Would you please read and *circle your answers* to the following questions and then sign the document.

- **I do** / **do not** authorise recording of such information as is necessary for the adequate provision of the service I have sought.
- **I do** / **do not** authorise the disclosure of my personal information to my spouse / partner upon his / her request.
- **I do** / **do not** authorise my health professional to contact me in the future if he / she becomes aware of information that may assist me or in order to follow up on any unresolved matter.
- **I do** / **do not** authorise my health professional to use my de-identified data for future research or to us my chart for training purposes.
- **I do** / **do not** authorise the use of my de-identified story for promotional purposes.
- **I do** / **do not** authorise the use of my identified data to other health professionals in order to provide best practice care.
- **I do** / **do not** consent to SMS contact / reminders from the Centre for Health and Wellbeing.

Patients are responsible for all account payments. If you are unable to attend an appointment we would appreciate at least 24 hours' notice so that another patient may benefit from this time. If you cancel on the day of your appointment a non-attendance fee of $60-00 (30 minute consult) or $30-00 (15 minute consult) will apply. If you miss an appointment without notice, <u>you will be charged the full fee</u>. These fees are <u>not</u> claimable through Medicare.

I am responsible for the full amount fees and I declare that the above information to be true and correct

Signed _____ Today's date _____

We accept Eftpos, Credit Card, Cheque or Cash (Not Amex or Diners)

NaProTECHNOLOGY

CENTRE FOR Health and Wellbeing

PMS SCREENING QUESTIONNAIRE **Today's date** _____

Name _____ Age _____

PMS is often a marker of hormonal abnormality so it is very relevant to your assessment

In the following table, please indicate which of these symptoms you experience at least 4 days before your menstrual period. In addition, only list symptoms that are then relieved within the first couple of days of your period and that have been present in at least 3 out of the past 6 cycles.

Please indicate the severity of symptoms as follows:

0 = none
1 = mild, does not interfere with activities
2 = moderate, interferes with activities but is not disabling
3 = severe, disabling

Also, list the number of days that each symptom is present.

SYMPTOM	Severity	# Days
I feel depressed or hopeless		
I have headaches		
I feel tearful or cry easily		
I feel "on edge, irritable, anxious or wired"		
I have decreased interest in my usual activities		
I have difficulty concentrating		
I feel easily fatigued; lack energy		
I have food cravings (salt, foods high in sugar or chocolate)		
I have trouble sleeping or sleep more than usual		
I feel overwhelmed or out of control		
I have breast tenderness		
I have a sensation of bloating or temporary weight gain		

Fertility Past History

Name: _____Age: ____ Date: _____

General Past History (TICK IF YES)

Thyroid problems		Stress	
Significant weight gain/ loss		Nickel allergy	
Diabetes/ gestational diabetes/ pre-diabetes		Skin rashes/ dermatitis	
Other/ details:			

Gynaecological History (TICK IF YES)

Pelvic Infections		Thrush	
Herpes		Gonorrhea	
Chlamydia		Other:	

Ovarian Cysts		Polycystic Ovary Syndrome	
Endometriosis		Abnormal Pap Smears	
Painful intercourse		Breast Problems	
Other:			

Menstrual History

Age at first period		Heavy periods	
Period length (bleeding days)		Spotting in cycle or brown bleeding	
Average Cycle length (total between periods)		Pelvic pain	
Longest Ever Cycle		Pre-menstrual syndrome (PMS)	
Shortest ever cycle			

Family History (tick if yes)

Diabetes		Miscarriages	
Endometriosis		Infertility	
Thyroid problems		Other:	

Social History

Married / Defacto / Single (please circle) if partner- Length of time _____

Pregnancy History

☐ Not applicable

Times Pregnant _____ Miscarriages _____

Premature births < 36 weeks _____ Induced abortions _____

YEAR	OUTCOME *(birth/miscarriage/induced abortion)*

History of Fertility Tests, Procedures and Treatments

☐ Not applicable

TEST	Y/N	DETAILS
Day 21 progesterone		
Semen Analysis		
AMH		
Ultrasound Pelvis/Follicles		
Other		

Fertility Procedures

☐ Not applicable

PROCEDURE	Y/N	DETAILS
HSG (Hysterosalpingogram or tube studies		
Hysteroscopy		
Laparoscopy		
Other		

Fertility Medical Treatments

☐ Not applicable

MEDICAL TREATMENTS	Y/N	DATES (approx.)/ DETAILS
Contraceptive pills		
Mirena		
Implanon		
Clomid or Serophene		
Injectable Hormone Treatment		
ART Treatments: ● *IVF* ● *ICSI* *GIFT* ● *ZIFT* ● *Artificial Insemination – Intrauterine (IUI)* ● *Husband (AIH)* ● *Donor (AID)*		
Other		

Fertility Surgical Treatments

☐ Not applicable

TREATMENT	Y/N	DETAILS
Cervix Surgery		
Uterine Surgery		
Ovarian Surgery		
Tubal Surgery		
Other		

QUESTIONNAIRE

CENTRE FOR Health and Wellbeing

Surname _____ Given name (s) _____ Today's date _____

MEDICAL HISTORY

Current health issues **please include sleep issues and any bowel issues* _____

Previous medical history. Please bring all the medical results you have from the last 6 months **please include any history of fractures, cardiovascular issues like palpitations, infertility issues*

Previous surgical history _____

Allergies and / or any sensitivities to particular foods, drugs or dressings _____

Medications / Supplements **please bring your medication and supplements with you to the consult* _____

Vaccinations _____

SOCIAL AND LIFESTYLE HISTORY

Alcohol ☐ non-drinker ☐ drinker ☐ monthly or less ☐ 2-4 per month ☐ 2-4 per week ☐ 4+ per week

Smoking ☐ never ☐ ceased smoking _year_ ☐ smoker #____ per day week

Vigorous activity ie: *running, swimming, aerobics, tennis, bike riding ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4+days ☐ never

Activities ie: *meditation, yoga, gardening, swimming, dancing, other ☐ yes ☐ no

Marital status ☐ single ☐ married ☐ de facto

Occupation _____ Pets _____

Overseas holidays (within the last 12 months) _____

Surname _____ Given name (s) _____

FAMILY HISTORY (if known) **please include history of heart problems, thyroid issues, diabetes, cancers, high blood pressure, depression and anxiety, bone period and joint problems, pregnancy problems, other*

Mother _____

_____

Father _____

_____

Sister/s _____

_____

Brother/s _____

_____

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Maternal or Paternal Aunts _____

Maternal or Paternal Uncles _____

Maternal or Paternal Children _____

FOR WOMEN ONLY

Date of last cervical screen _____	Number of children _____	Painful periods _____
Number of pregnancies _____	Post-natal depression _____	Heavy periods _____
Number of miscarriages _____	Age when first used pill _____	PMT _____
Last mammogram _____		

IS THERE ANY OTHER INFORMATION that you believe we should know that may affect or have an influence on the medical treatments / advise you will be provided with?

_____

_____

_____

_____

Please provide your main reasons for visiting us _____

_____

_____

Thank you! The information you have provided is Confidential and is valuable in guiding your medical care.

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3