

Patient Assessment Form

Please answer the questions as fully as you can, then upload a scan or photo on your booking page, or email it to the clinic.

This questionnaire is important for Dr. Georgiou to get a good 'picture' of your health issues, so please answer the questions as fully as you can and add anything else that you think is important or meaningful. Please note that your medical files will be kept strictly confidential and only Dr. Georgiou will have access to this form.

1 Personal details

Surname	
First name(s)	
Title	☐ Mr ☐ Miss ☐ Mrs ☐ Dr.
Date of birth	
Gender	
Height	
Weight	
Occupation	
Marital status	
No. of children	
Full address	
City	
Postal / Zip code	
Country	
Phone (include international dialling code)	
Phone (mobile)	
Email	

2 Medical details

Who referred you?

Your doctor(s)' name, specialty, and contact details

Your dentist's name and contact details

3 Medical history

What are your current symptoms?

How long have you been suffering from the above symptoms?

Does anything make your symptoms worse / better?

Has your condition been given a medical name / diagnosis? If so, what?

Please list all your medications, including vitamins, minerals, herbs, and homeopathics

Drug name	Dose	Frequency	Duration	Any benefits	Any side-effects

Do you have any known allergies to drugs, foods, animals, materials, etc?

Substance name	Reaction you had

Please list any other conditions you suffer/have suffered from, e.g. asthma, high blood pressure, diabetes, epilepsy, childhood illnesses etc.

Please list any previous surgical operations, together with dates (include any accidents/fractures/trauma)

Blood type

☐ A ☐ B ☐ AB ☐ O ☐ Don't know

Have you ever had a blood transfusion? If so, when and why?

Does anyone else in your family or in your workplace suffer from the same symptoms/disease as you?

4 Nutrition

Did/do you drink coffee?

Yes ☐ No ☐

How many cups per day?

How many years?

If you quit, when?

Did/do you drink black tea?

Yes ☐ No ☐

How many cups per day?

How many years?

If you quit, when?

Did/do you drink carbonated beverages, e.g. Coke, 7Up, Tango etc.?

Yes ☐ No ☐

How many years?

Do you drink "Diet" drinks, e.g. Diet Coke?

If you quit, when?

Do you consume alcohol? If so, how much and how often?

How much and how often?

What kind of alcohol?

Do you eat large or regular amounts of chocolate and sweets?

What is your water source?

Water source

How much do you drink (cups / litres)?

Do you eat organic fruits and vegetables?

Write down everything you eat and drink over a typical two-day period. (Include condiments, snacks, sweeteners, drinks etc.)

	Day one	Day two
Breakfast		
Lunch		
Dinner		
Snacks		

Are you happy with your eating habits?

Do you exercise? If so, what kind of exercise, and how often?

5 Emotions

Are you happy where you live now? If not, why?

Have you always lived there? If not, briefly mention towns/cities/countries you have lived in the past (since childhood)

Is your occupation stressful? If so, why?

How is your relationship with your co-workers?

How is your relationship with friends and family?

Any problems? _____

Are there any stressful circumstances in your life right now? _____

Are you traveling extensively? _____

6 Environment

Do you have any pets? _____

Are / were you a smoker?

Yes ☐ No ☐

If so, what do / did you smoke? _____

How many per day? _____

How many years? _____

If you quit, when? _____

Do you / have you ever tried recreational drugs?

Yes ☐ No ☐

If so, what? _____

Frequency? _____

How many years? _____

Do you have metal dental fillings? If so, how many? _____

Have you had any removed? If so, how many and when? _____

Did you follow a detoxification protocol with / after their removal? If so, what did it involve? _____

Do you have root canals? If so, how many? _____

Do you have crowns or other metals in your mouth? If so, what? _____

Do you use, or have you used, aluminum cookware? _____

Do you use, or have you used, spray deodorants or antiperspirants? If so, what kind? _____

Do you use, or have you used, hair colour dyes or bleaches? If so, what kind? _____

What cosmetics do you use regularly?

Do you use antacids?

Are you now on or have you ever taken birth control pills?

Yes ☐ No ☐

How many years?

Are you now or have you ever been on hormone replacement therapy (HRT)? If so, for how long?

Please list all your immunizations/vaccinations, together with dates

Have you ever taken antibiotics? If so, how many times?

How many times?

For what reason?

What kind of heating/air-conditioning do you have in your home?

What kind of heating/air-conditioning do you have at work?

Has there been any kind of remodeling/construction in your home recently?

Do you live or work near any farms, large agricultural areas, nuclear reactors or military bases? If so, what kind and how many miles away?

Have you ever been exposed to toxins of any kind? What?

Are there any high-tension lines or step-down transformers near your home or work?

Tick any of the following that you use:

☐ Micro-wave oven

☐ Electric blanket

☐ Water bed

☐ Fluorescent lights

☐ Computer ___ h/day

☐ Television ___ h/day

☐ Mobile/cell phone ___ h/day

Do you have any scars on any part of your body, and if so, where exactly?

7 Anything else

Is there anything else you wish to add, which you think may be relevant?

Thank you for taking the time to complete this important questionnaire. If you have any questions whatsoever, please do not hesitate to contact us. Please keep a copy of this questionnaire for yourself.