ORA clinic
Well Being, Health and Longevity

Date today:

Surname:		**Photo:**
First Names:		
DOB:		
Address:		
Phone Hm:		
Phone Wk:		
Mobile:		
Email:		
NHI:		
GP:	**Medical Clinic:**	
Spouse/Partner	**Spouse/ Partner Phone:**	

List *Your* Important Current and Past Medical History			
Date of onset	What is the diagnosis?	Condition active?	Or resolved?

List Important *Family* Illnesses				
Father	Mother	Brothers	Sisters	Grandparents

Dental Health	Occupation now -
Silver Amalgams?	
Any Root Canals?	Past Occupations -

Special tests or procedures				**Current Medications and supplements**
	✓	Year	Results	
Colonoscopy				
Gastroscopy				
MRI				
CT Scans				
Mammography				
Ultrasound				
ECG				
Angiogram				
Bone Density				
Hair Analysis				
X Rays				
Other special tests?				

Office Use Only				
General Consent Form	☐			
Declined Contact GP	☐			

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Please ✓ if you use or have:							
perfumes	☐	house cleaners	☐	drink from plastics	☐	new home	☐
hair dyes	☐	use paints	☐	mould in home	☐	very old home	☐
other body products	☐	weed, insect sprays	☐	mould in workplace	☐	other workplace	☐
recent vaccinations	☐	home pest products	☐	air conditioning	☐	chemicals	☐

List any exposure to chemical toxins:

Please ✓ if you have (or had) exposure to Heavy Metals:									
Lead	☐	Mercury	☐	Arsenic	☐	Cadmium	☐	Other	☐

Lifestyle questions (Tick most applicable)

My work is: ☐High Stress ☐Low Stress	Leisure Time: ☐A lot ☐Occasional ☐Never
My home life is: ☐High Stress ☐Low Stress	Exercise: ☐A lot ☐Occasional ☐Never

Do you consider your diet is: ☐Excellent ☐Could be better ☐Poor

Do you think your weight is: ☐Very good ☐Overweight ☐Underweight

General Quality of Life Assessment

Tick the **number** that you think best represents you:

	Very Bad			**Average**				**Excellent**		
Please rate	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
My overall health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Energy level overall	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Morning energy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Pattern	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Memory	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Appetite	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Motivation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Body Shape	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Concentration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Do you feel the heat	☐Yes ☐No ☐Sometimes									
Do you feel the cold	☐Yes ☐No ☐Sometimes									

*SO WHAT ARE THE **MAIN** HEALTH PROBLEMS THAT **MOST** CONCERN YOU*

1

2

3

4

General Health Information

Please indicate if you have:

Digestion System	✓		**Brain and Nerve System**	✓	
heartburn, reflux			anxiety		
bloating			depression		
wind			tinnitus (ear noise)		
abdominal pain			pins and needles		
constipation			numbness		
loose stools			vision problems		
blood in stools			hearing problems		
mucus in stools			poor memory		
irritable bowel			migraines		
mouth ulcers			headaches		
fatty foods reaction			restless legs		
sweet craving			dizziness		
change in bowel habit			vertigo		
intestinal infections			cramps		

- list known **food intolerances**

Respiratory System	✓		**Heart and Circulation**	✓	
hayfever			angina		
sore throats			chest pains		
cough			poor circulation		
asthma			leg clots		
sinus trouble			blood disorder		
mucus in throat			anaemia		
chest infections			short of breath		
			palpitations		
Immune System	✓		swelling of ankles		
skin infections			blood pressure		
lot of sore throats, colds			vein clots		
bladder, kidney infections					
cold sores			**Muscles, Joints**	✓	
genital herpes HSV II			sore muscles		
thrush (candida)			very weak muscles		
tinea			losing muscle		
other infections?			pain in joints		
			swelling of joints		
Skin	✓		back or neck pain		
psoriasis					
dermatitis			**Mental health**	✓	
eczema			feel depressed a lot		
rashes			feel loss of enjoyment		
poor nails			memory getting bad		
poor hair			don't feel like living sometimes		
losing hair			Can't concentrate now		
dry skin			poor motivation		
excessive aging skin			wake up early		
			avoid social contact more		

General Health Information

Adult Male Section	✓		Adult Female Section	✓	
poor urine pressure			anxiety		
night urination			depression		
slow to start			night flushes		
body hot at night			day flushes		
night sweats, chills			sweats		
antisocial			depression		
low sex drive			moodiness		
erection problems			irritability		
loss energy			dry vagina		
loss of drive			abdom bloating		
feel depressed			breast pain, lumps		
get anxious			breast swelling		
tearful sometimes			panic attacks		
can't cope as well			palpitations		
palpitations			fluid retention		
can't concentrate			premenstrual PMT		
memory decline			periods regular		
muscle pains			periods irregular		
loss of muscle			no periods now		
irritable more			last period when		
headaches			hysterectomy		
PSA test done?			low sex drive		
last prostate exam			loss of sensual feelings		
infections?			ovary problems?		
losing body hair			pelvic infections?		
			losing hair all over body		

Write any further comments you have about your health or concerns: