Initial Consultation Form

DR KATE BRUNSDON

Name _____

DOB _____

Relationship status _____

Children? Ages if so _____

Regular GP details _____

Current Medications/supplements

_____

_____

_____

Chronic health conditions

_____

_____

_____

Family History:

Please indicate if family member is alive and if ever diagnosed with any specific cancer diagnoses, diabetes, heart disease, stroke, dementia)

Family Member	**Alive?**	**Age/Age of death**	**Disease**
Grandmother (s)	_____	_____	_____
Grandfather (s)	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Aunty (ies)	_____	_____	_____
Uncle (s)	_____	_____	_____
Brother (s)	_____	_____	_____
Sister (s)	_____.	_____	_____

Last screening date?

Cervical Screening Test _____

Mammogram/breast screen _____

Bone density scan _____

Colonoscopy/Faecal Occult Blood test _____

Skin check _____

Dental check _____

Please describe your:

Sleep

_____

_____

_____

_____

Stress levels and management techniques

_____
_____
_____
_____

Current exercise regime

_____
_____
_____
_____

Nutrition - average day on a plate

Breakfasts _____
Lunches _____
Dinner _____
Snacks _____
Desserts _____
Favourite 'treat' foods _____
Alcohol intake _____
Caffeine intake _____
Time you stop eating at night (roughly) _____

Do you smoke? _____

Anything else you want me to know?

_____
_____
_____
_____
_____