CAULFIELD FAMILY MEDICAL PRACTICE
Dr Stephen Dudakov MBBS Provider No: 49947AK

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Low Carb Health Questionnaire

First Name …….. **Surname** …….

D.O.B ……. **Medicare No** …… **Ref** …….

Address …… **Postcode** ……..

Phone No (H) …… **(W)** ……..…... **(M)** ……..

Email Address ……

Occupation ……. **Sex:** Female / Male

Allergies – Please list all food and medications that you are allergic to.

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Medications – Please list current medications, strengths and dosages.

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Height ……cm **Previous maximum weight**……..kg **Present Weight …….** Kg

Previous diets……..

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Past Medical History – Have you ever had any of the following?

☐ High Blood Pressure ☐ Diabetes ☐ Heart Disorder

☐ Muscle or Joint Disorder ☐ Gastro – intestinal Disorder ☐ Gynecological / Breast

☐ Blood Disorder ☐ Bone Disorder ☐ Mental / Psychiatric Disorder

☐ Ear Nose or Throat Disorder ☐ Neurological Disorder ☐ Respiratory Disorder

☐ Skin Disorder

If yes to any of the above please describe and give approximate year ……

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Operations ……

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Family History Please list all known illnesses and causes of death in known family relatives with particular attention to **heart, blood pressure, diabetes, cancer and stroke.**

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When was your last:

Cholesterol &/or Sugar Test …….

Which Laboratory……..

Thank you for your assistance.

Dr. S Dudakov

M.B.B.S.