BEST of BOTH

Welcome to Best of Both Wellness with Dr Julienne Fenwick, MBChB.

Kindly complete the questionnaire and send back to info@bestofbothwellness.com at least 24 hours prior to your appointment. Please note that your privacy is protected under the POPI Act, and all information is strictly confidential. Compulsory fields marked with an asterix (*).

We look forward to helping you on your journey to optimized health!

*Full name as on ID: _____*Preferred name: _____

Single/Married/Divorced/Widowed. *Email address:_____

*Cellphone number: _____*Next of Kin cellphone & name: _____

*Home address: _____

*Medical aid: _____*Plan option: _____*Membership number:_____

List your main concerns to be addressed at your appointment:

_____

_____

_____

_____

_____

List your current medical problems (chronic diseases):

_____

_____

_____

_____

List any medications you currently take, with dosage and duration of treatment:

_____

_____

_____

List any supplements you currently take with dosage and brand:

_____

_____

Known allergies to medications:_____

Past infections (Tick bite, Viral, Malaria, TB, etc):_____

Past surgical history:_____

Family history of cancer (be specific), heart disease, stroke, dementia (or other):_____

Lifestyle - Please complete the following in terms of your daily routine:

Breakfast_____

Lunch_____

Dinner_____

Snacks/cravings/treats_____

Water intake per day (litres) _____

Coffees per day_____Milk_____Sugar/sweetener_____

Alcohol intake per week (wine/other)_____

Smoking (cigarettes or other, number per day)_____

How do you **sleep**? (well, fair, poor, varies)_____Obstacles?_____Sleeping pill?_____

What time do you go to bed_____Wake up in the morning_____

Energy levels in the morning (good, varies, low)_____afternoon_____evening_____

Stress levels during the day (chaotic, high stress, relaxed, varies)_____

Traumas in the past that may contribute to your baseline stress levels (feel free to leave this section to be discussed in person)_____

Mood: would you say you suffer from depression or anxiety?_____

Gut function

How many times per day do you pass stool?_____

Circle if you have any of the following symptoms: Bloating/Nausea or vomiting/Reflux/Gas/ Abdominal cramps/constipation/diarrhea/blood in the stool/pale or yellow stools/pebbly hard stools.

Do you take laxatives or digestive enzymes or probiotics or acid reflux medicine?

Current weight_____ Ideal weight_____

Hormones Female

If you are menstruating: cycle length_____ Regular/Irregular?_____Heavy bleed_____

Severe PMS symptoms?_____. Thrush or discharge?_____

When was your last breast scan (ultra-sound or mammogram, date and result)_____

Papsmear (date and result)_____

Peri-menopause and **Menopause** (circle if yes): Do you suffer from hot flushes/Brain Fog/Irritable mood/vaginal dryness/low libido/weight gain/hair loss/hair growth on face? Have you tried HRT?

Hormones Male

Do you suffer from erectile dysfunction/low libido/loss of muscle mass/hair loss/urinary issues?

Most recent PSA result_____ and have you seen a urologist in the past year?_____