DR DAVID SAMRA

MBBS (Hons) B App Sci (Physio)
438511HH
Sport & Exercise Medicine
Ultrasound guided procedures

SPORTS LAB ALEXANDRIA
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NSW 2015

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MEDICAL QUESTIONNAIRE

NAME: _____

D.O.B: _____

REFERRER NAME _____

***REFERRER ADDRESS/EMAIL**_____

Providing accurate information is the key to getting the best care.

BEFORE YOU CONSULT DR SAMRA, PLEASE ENSURE YOU HAVE:

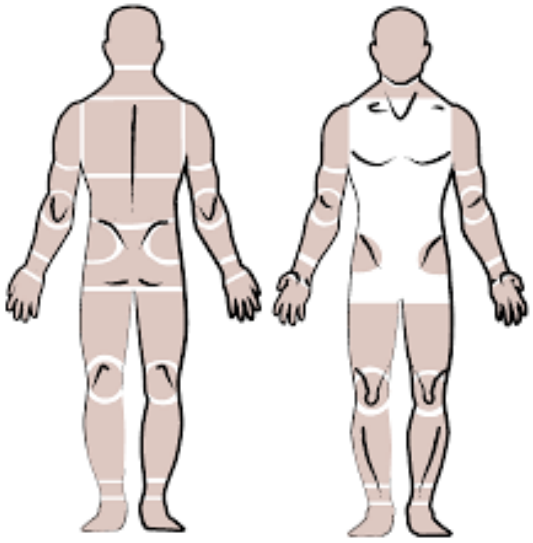
LETTERS
All health practitioner letters or relevant reports
(A GP referral is NOT required)

IMAGING
All relevant medical imaging (any x-rays or scans and the reports-
call the radiology practice to ensure it is available online or on CD)

CLOTHES
Shorts for lower limb injuries, sleeveless top or sports bra for upper limb injuries

PAPERWORK
Any Third Party paperwork e.g. Insurance or Work-cover
Note: Late requests for paperwork performed OUTSIDE consult time require an additional consult or attract an additional preparation fee

On the body map please mark the LOCATION of your current problem
If more than one area, please ensure you have a prolonged consultation (45 minutes)



Please rate any PAIN out of 10
(10 being the worst imaginable)

__
10

Please rate any IMPAIRMENT
out of 10 (daily/sport activities)

__
10

How long have you had this problem AND was there an incident?

_____

What INVESTIGATIONS (scans or other) have you had to date?

_____

What TREATMENT have you had to date?

_____

What do you think might be the main FACTORS causing this problem?

_____

What ACTIVITIES or EXERCISE do you enjoy most?

_____

TRAINING DIARY

How many days of the week are you currently exercising?

Outline your usual exercise regime below

Exercise (Type)	Frequency (/week)	Intensity	Duration (mins)

General Medical Questions

MEDICAL HISTORY: List any conditions requiring treatment or surgery

Body Area	Treatment/Operation	Year

MEDICATIONS (including vitamins/supplements)

Name	Reason Taken	Dose (mg)	Frequency

List all allergies (medication, food, other):

_____

(Circle): Smoker/ Non-Smoker/ Ex-smoker

Current Alcohol intake (quantity and frequency):

_____

Family History (Arthritis, Diabetes, Heart Disease, Other):

_____

Are you on a diet or trying to lose weight? Yes / No

Are you having any issues with sleep or recovery? Yes / No

Have you had current/previous issues with mood/mental health? Yes/ No

(Females only)

Have you had current/previous menstrual irregularity? Yes / No