Dr Charles J Forsyth MBBS FFHom
North Cottage 11 Dovers Green Road Reigate Surrey RH2 8BU Tel: 01737 226338

Dear patient

You now have an appointment to see Dr Forsyth, either at North Cottage, Dovers Green Road, Reigate, or Biolab Medical Unit, London.

If for any reason you need to cancel, please inform us immediately so that your appointment can be offered to someone on the waiting list, failure to do so will incur a charge.

It is essential that you complete ALL four questionnaires below and bring them to your appointment. *If you need further copies, they are available at:* http://www.dr-forsyth.com/Dr_Charles_Forsyth/Downloads.html):

- Practice Information
- Map & Directions
- New Patient Questionnaire
- Ecological Questionnaire
- Symptom Questionnaire
- Diet Diary

The questionnaires are quite demanding in terms of the amount of time and effort required to complete them - allow yourself several days to do the work required. You may need to contact other people (eg. relatives, your GP, your specialists) for some of the information requested.
Please complete them as fully and clearly as possible as they will become part of your permanent medical records. All information you provide is, of course, treated as strictly confidential.

We now ask for the following sections of the New Patient Questionnaire to be word-processed *(as simple text documents,* ***not*** *tables)* ***and emailed to me before your appointment***, instead of completing these sections in writing in the forms:

- **Symptom / Problem Details**
- **Medication and Supplement list**
- **Past Medical History**
- **Family History**

Your first appointment as a new patient will usually be for the duration of 90 minutes (unless you have booked a shorter or longer one). During this consultation Dr Forsyth will try to obtain a full medical history and discuss what can be done to help improve your health and resolve your problems. If you have multiple problems or if your case is complex, a further appointment may be required to make a full enough assessment and decide on investigations and discuss appropriate treatment. If you feel that the latter may be applicable to yourself, you are welcome to discuss it with us and book a longer or extra appointment in advance

A letter of referral from your family doctor is much appreciated. This is particularly helpful for accurate details concerning your past and present medical history, diagnoses, investigation results and treatment.

Biolab Medical Unit The Stone House 9 Weymouth Street London W1N 3FF
Mobile phone: 07802 293006 Home phone: 01737 248605 E-mail: office@dr-forsyth.com
GMC No: 2372909 www.dr-forsyth.com Partner: G M Forsyth

Before your first appointment, please ensure that you have read:

1) The Practice Information (also on the website and available as a download or by post from the office).

2) As much of the website as possible, especially the page 'Your First Appointment' so that you are clear about: A) the difference in approaches between conventional, homeopathic and ecological medicine, and B) the fee structure.

What to Email before your First Appointment:

Word-processed documents - emailed to me well before your appointment (instead of completing these sections in the questionnaires):

- **Symptom / Problem Details**
- **Medication and Supplement list**
- **Past Medical History**
- **Family History**

What to bring to your First Appointment:

- All *four* Questionnaires.
- *Copies* of any **Investigation results** - preferably all those of the last year or two - eg. blood tests, x-rays, scans.
- *Copies* of any relevant **Specialist letters**.
- *A letter of referral* from your family doctor, if available.
- *All your medications*: drugs, medicines, dietary supplements, creams, drops, lotions, etc. that you are currently taking.
- *A photograph* of yourself (or your child, if bringing your child) to go in your medical records. This is very helpful for bringing you to mind when I am working on your case without you present.
- *A spare adult* - if bringing a child under seven years old.

Please note that *settlement of all accounts is required at the time of consultation* - and we regret that we do **not** have the facilities to accept Switch or Credit Cards. Any patients wishing to claim on their medical insurance (BUPA, etc) are required to settle our fees at the time of consultation and then claim reimbursement themselves from their insurers.

We look forward to seeing you

Yours sincerely

RECEPTIONIST TO DR FORSYTH

Dr Charles J Forsyth MBBS FFHom
North Cottage 11 Dovers Green Road Reigate Surrey RH2 8BU Tel: 01737 226338

REGISTRATION FORM

Title: Mr ❑ Mrs ❑ Miss ❑ Master ❑ Other ....

Surname ....

Forenames .... (please indicate *used* forename)

Address ....

.... Postcode ....

Tel. Home .... Fax Home ....

Tel. Work .... Fax Work ....

Mobile ....

Email address ....

Temporary address (if applicable) ....

.... Postcode .... Tel: ....

Date of birth .... Country of birth .... Age ....

Marital status: Married ❑ Single ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed ❑

Maiden name .... Religion ....

Occupations (or previous if retired or unemployed); school or college (if a child or student):

....

....

Spouse / partner's name .... Occupation ....

Father's name .... Occupation ....

Mother's name .... Occupation ....

Next of kin .... Tel ....

Do you have Medical Insurance? .... Yes ❑ No ❑ Company name ....

Policy in the name of .... Policy No. ....

Authorisation No. .... Do you intend claiming? .... Yes ❑ No ❑

At which surgeries would you like to see Dr Forsyth? Reigate, Surrey ❑ Biolab, London ❑

Biolab Medical Unit The Stone House 9 Weymouth Street London W1N 3FF
Mobile phone: 07802 293006 Home phone: 01737 248605 E-mail: office@dr-forsyth.com
GMC No: 2372909 www.dr-forsyth.com Partner: G M Forsyth

Name & initials of your family doctor (GP) ....

Address .... Postcode ....

Do you have a letter of referral from your GP? - Yes ❑ No ❑

I consent to / do not consent to Dr Forsyth writing to my GP. Signed ....

Would you like to receive a copy? - Yes ❑ No ❑

Is there any information that you would like **not** included in a letter? - - - - - - - - - - - - Yes ❑ No ❑

Details ....

Name & initials of your specialist ....

Address .... Postcode ....

Do you have a letter of referral from your Specialist? - Yes ❑ No ❑

I consent to / do not consent to Dr Forsyth writing to my specialist(s). Signed ....

Do you see any other complementary therapists, (eg. osteopath, chiropractor, acupuncturist, healer)?

Name & initials .... Speciality ....

Address .... Postcode ....

Name & initials .... Speciality ....

Address .... Postcode ....

Name & initials .... Speciality ....

Address .... Postcode ....

From where or whom did you obtain Dr Forsyth's name & address? (Please give as much information as possible):

A Patient of Dr Forsyth's ❑ GP / Consultant ❑ Faculty of Homeopathy / British Homeopathic Association ❑

Osteopath / chiropractor ❑ Yellow Pages ❑ Thompson's Directory ❑ The Media ❑ Health Food Shop ❑

A Lecture ❑ A Chemist ❑ Another Therapist ❑ Internet search engine (eg. Google) ❑ Another website ❑

Please give some more detail ....

What are your **main reasons** for for seeing Dr Forsyth?

Fuller assessment ❑ More accurate diagnosis ❑ Second opinion ❑ Whole person approach ❑

Identification of: Nutritional deficiencies ❑ Allergies / sensitivities ❑ Toxic factors ❑

Advice / Management / Treatment: Homeopathy ❑ Diet & Nutrition ❑ Allergies ❑ Detoxification ❑

Stress management ❑ Life style factors ❑ Don't Know ❑

Other ....

I have read Dr Forsyth's Practice Information detailing his services and fees and accept and agree to these.

Signed .... Date ....

PERSONAL MEDICAL QUESTIONNAIRE

Please list all your **symptoms/problems** below, with the main ones first, providing for each: 1) *the date of onset*, and 2) *an estimate of how severely it troubles you* (scored out of 10: 10 = the worst it could possibly be, 1 = very trivial).

	Problem or Symptom	Date of Onset	Severity
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

Medications - please list ***all*** **drugs** (including contraceptive pill, HRT, sleeping tablets, asthma inhalers, creams, drops, lotions, suppositories, pessaries, etc.), **homeopathic medicines**, **nutritional supplements**, **herbal products**, etc. that you take - whether intermittently or constantly. Please supply name, make and dosage (eg. zinc 15mg).

	Name	Strength	Make	Dosage	Date Started
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

	Name	Strength	Make	Dosage	Date Started
15					
16					
17					
18					
19					
20					

LIFESTYLE QUESTIONNAIRE

Alcohol - on how many days of the week do you drink? ....

How much do you consume per day / week? ....

Tobacco - how much do you smoke? .... Since what age? ....

If you have now given up, between what ages did you smoke? ....

How much did you smoke? ....

Drugs - do you take any other "recreational" drugs, eg. cannabis, cocaine, ecstasy, etc.?

Which and how often? ....

If you have given up, what have you taken in the past? ....

Exercise - how much do you take and in what form(s)? ....

....

Relaxation - how much do you take and in what form(s)? ....

....

Sleep - what time do you normally go to sleep? .... and wake up? ....

Do you have any sleeping difficulties? ....

Occupation, school, college - what hours and days do you normally work in an average week? ....

....

What is your travel time to & from work? ....

Are you happy with your work? If not, please detail: ....

....

Relationships - do you have any difficult ones? ....

....

Interests, hobbies & pastimes - what are your main ones? ....

....

....

Stresses - what are the main ones in your life and how do they affect you? ....

....

....

Tiredness, fatigue, lack of energy - do you suffer inappropriately from any of these?

Yes ❑ No ❑ If so, give details & since when? ....

....

Childhood - did you have any particularly stressful or unhappy times? ....

....

....

....

DIETARY QUESTIONNAIRE

Are you following any **Special Diet**? Eg: Vegetarian ❑ Vegan ❑ Diabetic ❑ Low fat ❑ Wholefood ❑ Organic ❑ High fibre ❑ Calorie controlled ❑ Macrobiotic ❑ Gluten-free ❑ Milk-free ❑ Low carbohydrate ❑ or any other? - Please give details & for how long? ....

....

Food & Drink Consumption

Please estimate as accurately as you can what quantity of the following you consume on average:

Coffee		cups/mugs	per **day**
Tea		cups/mugs	per **day**
Soft/ carbonated drinks, eg. squashes, Coke, Fanta		glasses	per week
Fruit juices		glasses	per week
Plain water		glasses	per week
Sugar		teaspoons	per week
Confection: sweets/ chocolate		quantity	per week
Sweet biscuits		number	per week
Cakes		slices/pieces	per week
Puddings / desserts		number	per week
White bread		slices	per week
Wholemeal bread		slices	per week
Pasta		how many meals	per week
Rice		how many meals	per week
Potato		how many meals	per week
Mammal meat (beef, pork, lamb, etc.)		meals	per week
Poultry (chicken, turkey, etc.)		meals	per week
Fish		meals	per week
Eggs		number	per week
Cheese		how often	per week
Yogurt, fromage frais		how many	per week
Milk		pints	per week
Pulses: beans, peas, lentils		how often	per week
Nuts and/or seeds		how often	per week
Fresh vegetables (not including potato)		number of 80g portions	per **day**
Raw vegetables & salad		number of 80g portions	per **week**
Fresh fruit		number of 80g portions	per **day**
Tinned, packeted or frozen foods		how often	per week
Convenience (ready-made) meals		how often	per week
Take-aways & meals out (eg. cafe, restaurant)		how many	per week

Cravings - please list all foods or drinks that you ever have or have had cravings for. When do they or have they occur(ed)? ....
....
....

Aversions - please list everything that you can't stand the taste or smell of ....
....
....
....

ALLERGIES / INTOLERANCES / SENSITIVITIES / ADVERSE REACTIONS

Do you have or have you in the past had allergies, intolerances, sensitivities or adverse reactions to any of the following? Please tick and circle/ highlight and add as appropriate. If you have more than one or two in any section, please complete my "Ecological Questionnaire":

❑ **Foods, drinks, additives:** ....

❑ **Drugs:** aspirin/NSAIs, antibiotics, contraceptive pill, antimalarials, antihypertensives, statins, etc.

❑ **Immunisations:** DPT, Polio, HIB, MMR, BCG, tetanus, influenza, hepatitis, typhoid, cholera, smallpox, etc.

❑ **Inhaled/ airbourne:**

- **Chemicals/fumes:** tobacco, perfumes, traffic, diesel, petrol, paint, glues, plastics, solvents, etc.
- **Biological:** house dust, pollens, feathers, animals (eg. dogs, cats, horses, rabbits), fungal spores, etc

❑ **Skin/ contact:** cosmetics, soaps, shampoos, conditioners, detergents, woolens, elastoplast, rubber, nickel, jewellery, plants, animals (eg. dogs, cats, horses, rabbits), insect bites/stings, etc.

❑ **Electrical fields/ radiation:** mobile phones, wireless networks, computers, microwave ovens, etc.

MISCELLANEOUS

What is your Blood Group? **O** ❑, **A** ❑, **B** ❑, **AB** ❑ Rhesus: **Negative** ❑ **Positive** ❑
Are you: Dyslexic ❑ Colour blind ❑ Left handed ❑ Left footed ❑ Left eyed ❑

Dr Charles J Forsyth MBBS FFHom

North Cottage 11 Dovers Green Road Reigate Surrey RH2 8BU Tel: 01737 226338

PAST MEDICAL HISTORY

An accurate chronological medical, personal and social history is vital in understanding your present state of health. Please give yourself plenty of time to reflect, recall and assemble all the relevant information. Ask relatives and your GP for any details and dates that you are not sure of.

Please create *one* list, in strict chronological order, of all the following details about your past medical, personal and social history, giving *both* date and age.

Preferably create as a Microsoft Word (or Apple Pages) document & bring to your appointment - and also email a copy to my office. If word-processing is not possible, first assemble all the information in order, in rough and then complete the PMH form supplied - and continue onto the other side if necessary.

- All past and present ill-health. Include: all problems that you have entered on page 3 of this (and the Systems Review) questionnaires, childhood diseases, serious illnesses, recurrent illnesses, all diseases, infections, problems and dental troubles.
- Details of your mother's pregnancy and your delivery, birth weight, Apgar score, duration of breast feeding and your developmental milestones.
- All operations (including dental) and spells in hospital.
- All drug treatment, past and present, giving approximate date started and duration of treatment. Please include all sleeping pills, contraceptive pills, tranquillizers, antidepressants, antibiotics, steroids and steroid creams, blood pressure pills, hormones, etc.
- Adverse reactions to any drugs, hormones (contraceptive pill, HRT, etc.), immunizations, operations or other medical procedures or therapies.
- Approximate dates of all smallpox vaccinations.
- Abnormal medical investigations, including blood tests, X rays, scans, etc.
- Any serious injuries, including head injuries.
- Major life events. eg. Marriages, separations, divorces, death of loved ones, adoption, etc.
- Major emotional upsets, spells of depression, anxiety, tension, anger, etc.
- Females only - Please list:
    - When you had your first period.
    - Period problems, including: spells of heavy, light, long, short, absent or painful periods, premenstrual symptoms, infertility, etc.
    - All pregnancies and deliveries, including: birth weights, how long breast fed, miscarriages, abortions, stillbirths, inductions, use of forceps, caesarean sections, problems during them (persistent vomiting, high blood pressure, pre-eclampsia, etc.), multiple pregnancies, babies with congenital abnormalities, etc.
    - If you have had the menopause, did you have any problems with it and what was the date of your last period?

22/01/2014

Biolab Medical Unit The Stone House 9 Weymouth Street London W1N 3FF

Mobile phone: 07802 293006 Home phone: 01737 248605 E-mail: office@dr-forsyth.com

GMC No: 2372909 www.dr-forsyth.com Partner: G M Forsyth

PAST MEDICAL HISTORY FORM

YOUR MOTHER'S PREGNANCY ....

YOUR DELIVERY ....

AT HOW MANY WEEKS .... DATE OF BIRTH ....

INDUCED: ◻ Rupture of membranes ◻ Pessary ◻ Drip

◻ FORCEPS ◻ VENTOUSE ◻ CAESARIAN

◻ PETHIDINE ◻ GAS & AIR ◻ EPIDURAL ◻ GENERAL ANAESTHETIC

YOUR CONDITION AT BIRTH ....

YOUR BIRTH WEIGHT ....

DURATION BREAST FED ....

AGE WEANING BEGAN ....

DATE	AGE	

IMMUNISATIONS

(Tick + give dates, if possible)

- ◻ SMALLPOX:
- ◻ DIPHTHERIA:
- ◻ WHOOPING COUGH:
- ◻ TETANUS:
- ◻ HIB:
- ◻ POLIO:
- ◻ MEASLES:
- ◻ RUBELLA:
- ◻ MUMPS:
- ◻ MENINGITIS C:
- ◻ PNEUMOCOCCAL:
- ◻ HPV:
- ◻ BCG (TB):
- ◻ INFLUENZA:
- ◻ HEPATITIS A:
- ◻ HEPATITIS B:
- ◻ CHOLERA:

IMMUNISATION REACTIONS

DRUG SENSITIVITIES

FOOD SENSITIVITIES

INHALANT SENSITIVITIES

SKIN/CONTACT SENSITIVITIES

FAMILY HISTORY FORM

Please give the year of birth and age at death of the following members of your family together with all their past and present health problems, ailments, diseases, operations, etc. Particularly relevant are be those problems that you also have or have had. Please include any of the following:
Addison's disease, Aids, Alcoholism, Allergies (drug, chemical, food, inhalant, skin), Alopecia, Angina, Anxiety, Asthma, Attention deficit disorder, Birth defects, High blood pressure, Cancer, Cataract, Chest trouble, Cirrhosis, Coeliac disease, Colitis, Crohn's disease, Cystic fibrosis, Dementia, Depression, Dermatomyositis, Diabetes, Drug abuse/addiction, Drug Allergies, Dyslexia, Early greying of hair, Eczema, Epilepsy, Glaucoma, Gonorrhoea, Hardening of arteries, Hay fever, Heart attack, Hodgkin's disease, Kidney disease, Leukaemia, Liver disease, Migraine, Mental retardation, Multiple sclerosis, Obesity, Operations, Osteoarthritis, Osteoporosis, Panic attacks, Parathyroid disease, Parkinson's disease, Pernicious anaemia, Phobias, Porphyria, Psoriasis, Rheumatoid arthritis, Schizophrenia, Stroke, Suicide, Syphilis, Systemic lupus erythematosis (SLE), Thyroid disease, Tobacco smoking, Tuberculosis, Urticaria (hives), Vitiligo.
Exposure to: Dental amalgam, Contraceptive pill, Toxic metals (eg. Mercury, Lead), Pesticides, Petrochemicals, Fluoride.

	Year of Birth	Age at Death	Details
MOTHER			
GRANDMOTHER			
GRANDFATHER			
FATHER			
GRANDMOTHER			
GRANDFATHER			
SISTERS			
BROTHERS			
MATERNAL AUNTS & UNCLES			
PATERNAL AUNTS & UNCLES			
DAUGHTERS & SONS			