WA IRON CENTRE

IRON DEFICIENCY - PATIENT QUESTIONNAIRE

Please complete the following details (2 sided)

PERSONAL DETAILS	
Surname	
First name	
Date of birth	

GP DETAILS	
Doctor's name	
Clinic name	
Address	
Phone	
Email	

BLOOD TESTS & INVESTIGATIONS
Please attach any relevant blood tests and investigations done since diagnosis of iron deficiency

SYMPTOMS OF IRON DEFICIENCY			
	NO	**YES**	**If yes, please specify**
Excessive fatigue / tiredness			
Decreased memory or concentration			
Headaches and/or dizziness			
Increased shortness of breath with exercise/exertion			
Heart palpitations			
Paleness			
Dry and damaged skin and hair			
Swelling and soreness of tongue and mouth			
Restless legs			
Cold hands and feet			
Increased infections (e.g., respiratory, urinary tract, skin, or gastroenteritis)			

MENSTRUAL HISTORY (please complete if female)			
	NO	**YES**	**If yes, please comment:**
Menopausal (i.e., no more periods)			Approx. age of onset of menopause: (If yes, you do not need to complete the rest of this section)
I am pregnant			PLEASE NOTE: iron infusion contraindicated during first trimester

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I was recently pregnant			Date of delivery:
I am using hormonal contraception Please specify which type:			
I have regular menstrual cycle			
My periods are usually heavy (ie clots and flooding)			
My periods are usually painful			

DIETARY HISTORY			
	NO	YES	If yes please comment:
Do not eat meat at all (e.g. vegan, vegetarian)			
Eat very little meat (please specify about how often you would eat meat, e.g. once a week, once a month)			

HISTORY OF IRON DEFICIENCY			
	NO	YES	If yes, please specify when, what treatment was given and if cause was identified
I have been diagnosed with iron deficiency in the past.			

MEDICAL CONDTIONS (Please list medical conditions OR attach medical summary)

MEDICATIONS (Please list both prescription and non-prescription medications you are currently taking OR attach medication list)	ALLERGIES OR MEDICAL ADVERSE REACTIONS