Natural Harmony
Chinese Medicine Clinic

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Confidential Patient Health History

This information is essential in helping to make an accurate diagnosis and provide you with the most effective treatment possible. Please fill out this form completely and as accurately as you can.

Personal Information:

Name: ____

Address: ____

____

____

Occupation: ____

Phone hm: ____________________ wk: ___________

cell: ______________________

Email: ____

Physician Information:

Name: _________________________

Phone: ________________________

Emergency Contact:

Name: ________________________

Phone: ________________________

Sex: Male: ____ Female: ____ **Who referred you?** ___________________________

Date of Birth: _______________________ Age: ______

Height: ___________ Weight: ________ Blood Pressure: ___________ Date of last Physical:_____________

Describe your main complaint: ____

____

What has been diagnosed? (by a physician): ____

____

Are you currently being treated by a physician? Yes____ No_____ If yes, for what? ________________________

____

Any problems/complications with your birth? Please circle: Premature overdue C-section prolonged labor jaundice other (please specify): ____

Vaccination History: Any negative reactions that you remember? _________________________________

____________________________________ Any unusual vaccinations? ____

Surgeries & Injuries: List any surgeries (even minor surgeries) or injuries. Please only list major injuries or ones that have had a lasting impact. (us the back of this form if necessary):

Childhood

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Adolescence

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Adulthood

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Age: ______________ Surgery or injury: ____

Do you have any scars (even minor ones) from any of the above? Please list: ___________________________

____

Please place a check by any of the following that are part of your medical history:

____pregnancy (#_____) _____pace maker ____HIV+ ____hepatitis (type______)

____herpes (type _____) _____ bruise easily ____Seizures _____cancer (type __________________)

Family History

Has any member of your immediate family had any of these conditions? (Please letter by all that apply)

a. asthma	mother___________________
b. cancer	father ____________________
c. diabetes	brother __________________
d. seizures	sister ____________________
e. heart disease	maternal grandmother __________________
f. high blood pressure	maternal grandfather ____________________
g. stroke	paternal grandmother ___________________
h. alcoholism	paternal grandfather _____________________
i. high cholesterol	aunt ______________________
j. neurological disorders	uncle _____________________
k. psychological disorders	
l. orthopedic disorders	
m. food allergies (dairy, wheat, etc)	
n. thyroid disease	

o. other (please specify): ____

Medications/Supplements/Herbs/Vitamins/Minerals

Please list any medications, supplements, herbs, vitamins or minerals you are currently taking:

____
____
____
____

Is there anything else that is significant in your health history? __________________________
____
____

Symptom List

Circle any problems, disease, or symptom you have now. Underline items that affected you in the past

Skin: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

Heart and vascular: Fast pulse (over 100 beats/min.) slow pulse (less than 60 beats/min.) palpitation irregular pulse feeling of pressure in the chest short of breath chest pain dizziness migraine headache with nausea cold hands/cold feet Raynaud's disease flushed face anemia high blood pressure low blood pressure cold sweat red face feel dizzy or faint when standing up quickly or standing for a long time

Gastrointestinal: constipation diarrhea no appetite stomach pain indigestion heartburn intestinal gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spams peritonitis pancreatitis irritable bowel polyps GI tumors

Respiratory: asthma bronchitis emphysema cough wheeze pneumonia lung abscess

Hormonal imbalance: low thyroid overactive thyroid diabetes hypoglycemia blood sugar
Other hormone imbalance ____

Male: impotence premature ejaculation prostate gland problem vasectomy infertility

Female: menstrual problems cramping heavy//light/irregular periods PMS emotional reactions menopause symptoms tubal ligation infertility low libido

Autoimmune and inflammatory conditions: Hashimoto's disease (thyroid) rheumatism systemic lupus erythematosus colitis Crohn's disease alopecia (baldness) allergy food allergy atopic dermatitis neurodermatitis cellulitis sinus allergy vulvitis low immunity

Effects of focal infections: rheumatic disease rheumatic fever arthritis skin disease
Connective tissue or ligament diseases: Myofascial pain syndrome fibromyalgia tendinitis ligaments pericarditis constant slight fever glomerulonephritis plantar fasciitis scarlet fever ear infections streptococci infections staphylococci infections easily catch cold or sore throat swollen glands

Ear, nose & throat: deafness tinnitus (ringing in the ear) itchy ear ear pain frequent ear infections sinus head aches yellow mucus stuffy nose port-nasal-drip dry throat itchy throat constant sinus congestion streptococci throat infections sore throat

Oral disease: bleeding gums peridodontitis dental abscess mumps stomatitis (inflammation of the mouth) TMJ toothaches without cavities

General: insomnia psychosomatic weakness exhaustion emotional problems (angry, irritable, depressed, anxious) difficult concentrating on a task easily get car sick, sea sick, or air sick no appetite for breakfast moody in the mornings unusual sweating (palm, sole, or elsewhere) never sweat

Before noon time: no energy feeling spacey scattered mind energetic all evening through midnight, but hate to wake up early in the morning long shower or bath makes you feel dizzy or faint

Medication and drugs: birth control pill cigarettes alcohol cocaine marijuana

Other: ____
____
____
____
____
____

Name:_______________________________________ Date: _______________________

Signature: ____________________________________