

Health Summary

Name:		Date:	Update
Home ph:		May I call you at this number? Is it OK to leave a message?	Address
Work ph:		May I call you at this #? Is it OK to leave a message?	City, State
Cell ph:		May I call you at this number? Is it OK to leave a message?	Zip
e-mail		May I contact you via e-mail?	Drivers License #
Occupation		Religion/Spiritual preference:	Date of Birth
Marital Status		Name of significant other:	Age
Emergency contact (name/phone #)			

Past Medical History

Check things you have had in the past. Example:

x	High blood pressure
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Put "C" for conditions you are currently experiencing.

C	High Cholesterol
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Example:

Indicate when you had these conditions or when they were diagnosed by the year.

x	Rheumatic fever 1978
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Example:

AIDS	Congestive Heart Failure	HIV positive	Psychiatric care
Alcoholism	Depression	Joint replacement	Rheumatic Fever
Anemia	Diabetes	Kidney Disease	Rheumatoid arthritis
Anorexia	Drug Dependent	Liver Disease	Scarlet fever
Anxiety	Emphysema	Measles	Sexually transmitted disease
Appendicitis	Epilepsy	Migraines	Stroke
Arthritis	Glaucoma	Miscarriage	Suicide attempt
Asthma	Gonorrhea	Mononucleosis	Suicide thoughts
Bleeding Disorders	Gout	Multiple Sclerosis	Thyroid problems
Blood in urine	High blood pressure	Mumps	Tonsillitis
Breast Lump	Heart murmur	Panic Attacks	Tuberculosis
Bronchitis	Hepatitis	Pacemaker	Ulcers
Bulemia	Hernia	Pneumonia	Unconsciousness
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	Hiatal Hernia	Prostate Problem	Other:
Coma	High Cholesterol	Post Partum Blues	

Past Surgeries/Procedures (Include Dental—ex. Root canal, teeth pulled, include location)

Surgery	Date

Birth/Trauma History—Check (X) any box which apply and explain circumstances and when occurred.

Were you born by a Vaginal delivery?	Were you born by a c-section?
Motor vehicle accident—if so, when	Fall—if so, when, how high?
Other trauma:	

Social History—Check (X) any box that applies

Alcohol—	# drinks/day or week	Recreational drug use
Cigarette--	# packs/day	
Coffee/Tea/soda--	# cups/day	

Medications/Herbals/Supplements—dose and frequency, when started

Medication	Start

Allergies—List any medications that you have had an allergic reaction to and the reaction.

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Family History—If any blood relative has suffered from any of the following, please check (X) the box and indicate the relative

Allergies	Cancer	Heart disease
Asthma	Diabetes	High blood pressure
Anemia	Epilepsy/Seizure	Kidney/bladder problems
Arthritis	Glaucoma	Mental Illness
Alcoholism	Gout	Stroke
Blood Clotting Problems	Headaches/migraines	Other:

Consultants--Please list other practitioners you see—other physicians, chiropractors, acupuncturist etc and phone #

Review of Systems:

- X** Check things you have had in the past.
- C** Put "C" for conditions you are currently experiencing.

General	Cardiac/vascular	GU	Cold intolerance
Fever	Chest pain	Bladder control	Hair falling out
Chills	Chest pressure	Blood in urine	Excessive thirst
Night Sweats	Fainting	Decrease force or urine	Heme/lymph
Weight Loss	Heart murmur	Painful intercourse	Easy bruising
Fatigue	High blood pressure	Painful urination	Bleeding gums
Loss of energy	Irregular heart beat	Pelvic pain	Lymph nodes
Loss of sleep	Leg pain when walk	Sexual dysfunction	Allergies/Immune
Eye	Lightheaded	Urinary hesitancy	Seasonal allergies
Blurred vision	Low blood pressure	Neurology	Other allergies
Double vision	Pass out	Cold or numb hands/feet	Diet--# servings/day
Crossed-lazy eye(s)	Palpitations	Convulsions (seizures)	Water
Eye pain	Phlebitis	Frequent headaches	Soda
Loss of vision	Poor circulation	Muscle weakness	Meats
Visual Flashes	Shortness of breath	Numbness/tingling	Breads
Visual Halos	At rest	Tremors	Dairy products
Had laser surgeries	With exertion	Unsteady walking	Fruit juice
Wear glasses or contacts	Lying flat	Vertigo/spinning	Vegetables
Ear, Nose, Throat	Swollen ankles	Psychosocial	Other
Decreased hearing	Varicose Veins	Anxiety	Female only
Earache	Pulmonary	Depression	# of pregnancies
Ear discharge	Cough	Nervousness	# of live births
Ear fullness	Wheezing	Skin/breast	# of miscarriages/abortions
Ear infections	Gastrointestinal	Eczema	# vaginal deliveries
Ear ringing-buzzing	Abdominal pain	Hives	# c-sections
Hoarseness (prolonged)	Black stools	Itching	Method of birth control
Jaw Clicking	Bloating	Rashes	Periods are:
Jaw locking	Blood in stools	Yellow skin/eyes	Regular
Nosebleeds	Constipation	Breast lumps	Irregular
Post nasal drip	Diarrhea	Nipple discharge	Painful
Sinus problems	Heartburn	Endocrine	Heavy
Sore throat (frequent)	Hemorrhoids	Excessive weight gain	Scant
Swallowing difficulty	Nausea	Excessive weight loss	
	Vomiting	Heat intolerance	

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Review of Systems of TCM:

- X** Check things you have had in the past.
C Put "C" for conditions you are currently experiencing.

	Overall Temperature (kidney function)	Lung function		Incomplete		Irritability
	Cold hands	Nasal Discharge		Diarrhea		Frequently unable to adapt to stress
	Cold fingers	Cough		Blood in stools		Skin rashes
	Cold feet	Nose Bleeds		Mucous in stools		Headache at the top of the head
	Cold toes	Dry mouth		Undigested food in stools		Tingling sensation
	Sweaty hands	Dry throat		Dampness trapped in the body		Numbness
	Sweaty feet	Dry Nose		General sensation of heaviness in the body		Muscle spasms
	Hot body temperature (sensation)	Dry Skin		Mental heaviness		Muscle twitching
	Cold body temperature (sensation)	Allergies		Mental sluggishness		Muscle cramping
	Afternoon flushes	Alternating fever and chills		Mental fogginess		Seizures
	Night sweats	Sneezing		Swollen hands		Convulsions
	Heat in the hands, feet and chest	Headache		Swollen feet		Lump in the throat
	Hot flashes anytime of the day	Overall achy feeling in the body		Swollen joints		Neck tension
	Thirsty	Stiff neck		Chest congestion		Limited Range-of-Motion, Neck
	Perspire easily	Stiff shoulders		Nausea		Shoulder tension
	Lack of perspiration	Sore throat		Snoring		Limited Range-of-Motion, Shoulder
	Take water to bed	Difficulty breathing		Stomach function		Drink alcohol
	Overall Energy (lung, kidney function)	Smoke cigarettes (# of cigarettes per day: _____)		Burning sensation after eating		High-pitched ringing in the ears
	Shortness of breath	Sadness		Large appetite		Gall stones (history or current)
	Difficulty keeping eyes open in the daytime	Melancholy		Bad breath		Eyes (Liver function)
	General weakness	Spleen Function		Mouth (canker) sores		Itchy
	Easily catch colds	Low appetite		Bleeding, swollen or painful gums		Bloodshot
	Low energy	Abrupt weight gain		Heartburn		Hot
	Feel worse after exercise	Abrupt weight loss		Acid regurgitation		Dry
	Overall blood (Liver, Spleen, Heart function)	Abdominal bloating		Ulcer (diagnosed)		Watery
	Dizziness	Abdominal gas		Belching		Gritty
	See floating black spots	Gurgling noise in the stomach		Hiccoughs		Blurry vision
	Heart function	Fatigue after eating		Stomach pain		Decreased night vision
	Palpitations	Prolapsed organs (previously diagnosed, which organ? _____)		Vomiting		Near sighted
	Anxiety	Easily bruised		Liver, Gall Bladder function		Far Sighted
	Sores on the tip of the tongue	Hemorrhoids		Alternating diarrhea and constipation		Libido
	Restlessness	Pensive		Chest pain		Normal
	Mental confusion	Over-thinking		Tight sensation in the chest		High
	Chest pain traveling to shoulder	Worry		Bitter taste in the mouth		Low
	Frequent dreams	Spleen, Stomach, Large Intestine, Small Intestine function		Anger easily		
	Wake unrefreshed	Loose		Frustration		
	Drink coffee (# of cups per week: _____)	Constipated		Depression		

Kidney, Urinary Bladder function	Excessive hair loss	Urination	Strong odor
Frequent cavities	Low-pitched ringing in the ears	Normal color	Burning
Easily broken bones	Kidney stones	Dark yellow	Painful Discharge
Sore knees	Bladder infections	Clear	
Weak knees	Wake during the night twice or more to urinate	Reddish	
Cold sensation in the knees	Lack of bladder control	Cloudy	
Low back pain	Fear	Scanty	
Memory problems	Easily startled	Profuse	

History of Present Illness:

Please describe your problem in as much detail as possible. Include:

What all of your symptoms are--

When symptoms began--

What makes it **better or worse**--

Treatments tried and their effect on your problem --

All health care providers seen for this problem, the **diagnosis** they gave you, tests or x-rays done, and treatment given--