Health Summary

Name:		Date:	Update
Home ph:		May I call you at this number? Is it OK to leave a message?	Address City, State
Work ph:		May I call you at this #? Is it OK to leave a message?	Zip
Cell ph:		May I call you at this number? Is it OK to leave a message?	Drivers License # Date of Birth
e-mail		May I contact you via e-mail?	Age

Occupation	Religion/Spiritual preference:
Marital Status	Name of significant other:
Emergency contact (name/phone #)	

Past Medical History

Check things you have had in the past. Example:

x	High blood pressure

Put "C" for conditions you are currently experiencing. Example:

C	High Cholesterol

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

x	Rheumatic fever 1978

	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.

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--