Clinic of NaturalMedicine
where modern science meets ancient wisdom

Patient Medical Information Form

Date _____ **Surname** _____ **First name** _____
Address : _____

_____

Telephone : Work _____ Home _____ Mobile _____
E-mail address _____
D.O.B _____ **Occupation** _____ **Status** (married,single etc) _____
Name of GP _____
Address of GP _____

_____

Weight _____ **Height** _____.
Referred by _____

CHIEF COMPLAINTS :

PLEASE LIST PRESENT SYMPTOMS IN ORDER OF PRIORITY (worst first):

Symptoms	Date started	Known triggering factors

FAMILY HISTORY Please indicate whether any family members currently or in the past have had any of the following :

	Father	Mother	Father's parents Mother	Father	Mother's parents Mother	Father	Siblings	Children
Heart disease								
Respiratory disease								
Stroke								
Arthritis								
Cancer								
M E / Chronic Fatigue								
Diabetes								
Hypertension (High BP)								
Kidney disease								
Reproductive issues								
Mental illness								
Alzheimer's disease								
Alcoholism								
Other :								

Rate each of the following symptoms based upon your typical health profile by placing a tick on the line against each symptom that has been present for over the past 30 days.

HEAD	___ Headaches ___ Migraines ___ Faintness ___ Dizziness ___ Insomnia	Total _____
EYES	___ Spots in front of the eyes ___ Watery or itchy eyes ___ Swollen, reddened or sticky eyelids ___ Bags or dark circles under the eyes ___ Blurred or tunnel vision (Does not include near or far sightedness)	Total _____
EARS	___ Itchy ears ___ Earaches, ear infections ___ Drainage from ear ___ Ringing in ear, hearing loss	Total _____
NOSE	___ Sensitivity to chemical smells ___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucous formation	Total _____
MOUTH/THROAT	___ Food intolerance ___ Chronic coughing ___ Gagging, frequent need to clear the throat ___ Sore throat, hoarseness, loss of voice ___ Swollen or discoloured tongue, gums, lips ___ Mouth ulcers ___ Constant thirst	Total _____
SKIN	___ Acne ___ Hives, rashes, dry skin, eczema, psoriasis ___ Hair loss ___ Hot flushes ___ Excessive sweating	Total _____
HEART/CHEST	___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat (palpitations) ___ Chest pain ___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficulty breathing	Total _____
MUSCLE	___ Pain or aches in joints ___ Arthritis ___ Stiffness or limitation of movement ___ Pain or aches in muscles ___ Feeling of weakness and tiredness ___ Recurrent back/neck/shoulder aches	Total _____

DIGESTIVE TRACT

___ Shaking/irritable when hungry
___ Hypoglycaemia
___ IBS
___ Mucous in stools
___ Nausea, vomiting
___ Diarrhoea
___ Constipation
___ Bloated feeling
___ Belching, passing gas
___ Heartburn
___ Intestinal/ Stomach pain
___ Rectal itching

Total _____

FEET

___ Athletes foot
___ Bunions
___ Thick toenails

Total _____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods (eg sugar)
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy (no motivation)
___ Hyperactivity
___ Restlessness
___ Unrefreshed sleep

Total _____

MIND

___ Poor memory
___ Confusion, poor comprehension (brain fog)
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

EMOTIONS

___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability, aggressiveness
___ Depression
___ Panic attacks

Total _____

SEXUAL AND URINARY

___ Frequent Cystitis (painful urination)
___ Prostatitis (male)
___ Frequent or urgent urination
___Genital itching or discharge
___ Loss of Libido

Total _____

OTHER

___ Numbness, burning, tingling in extremities
___ Cold hands and feet

Total _____

Please add any presentation that doesn't appear on the list above

_____
_____

GRAND TOTAL _____

Officially Diagnosed DISEASES or ILLNESSES eg Diabetes Type 1_____
_____

Please rate your level of motivation to affect change in your health (10 = motivated)
1 2 3 4 5 6 7 8 9 10

Please rate your current level of Health (10 = excellent)
1 2 3 4 5 6 7 8 9 10

How many prolonged courses of steroids or antibiotics have you taken in the past year ?

None ___ 1x ___2x___3x___

In the past 5 years : 3x___4x___5x___6x___7x___8x___

As a teenager were you given long term antibiotics for acne, or other bacterial infections Yes _____ No _____
Did you suffer from attention deficit disorder (ADD) as a child ? Yes _____ No ____

PAST MEDICAL HISTORY

Childhood : Indicate if you have had any of the following childhood illnesses :

❑ **Asthma**	❑ **Measles**	❑ **Rheumatic fever**
❑ **Chickenpox**	❑ **Mumps**	❑ **Scarlet fever**
❑ **Eczema**	❑ **Polio**	❑ **Whooping cough**
❑ **Frequent ear infections or colds**	❑ **Rubella (German measles)**	❑ **Other**

Vaccination history : Indicate which of the following vaccinations you have received :

❑ **Hepatitis A**	❑ **Hemophilus influenza B**	❑ **Tetanus booster**
❑ **Hepatitis B**	❑ **Flu shot**	❑ **Smallpox**
❑ **MMR**	❑ **Polio**	❑ **Other**
❑ **Chicken Pox**	❑ **DPT**	**Specify**

Adulthood (significant illnesses) prior to your current health circumstances.

Surgery/hospitalisation (include dates) :

GENERAL HEALTH :

Exercise routine _____

Sleep pattern _____

When are your energy levels best ?

❑ Morning	❑ Mid - day	❑ Mid-afternoon	❑ Evening
❑ Between meals	❑ Just after meals	❑ When moving	❑ Night

When are your energy levels worst ?

❑ Morning	❑ Mid - day	❑ Mid-afternoon	❑ Evening
❑ Between meals	❑ Just after meals	❑ When moving	❑ Night

What is your assessment of your stress levels at present in terms of 1 out of 10
(1 being very relaxed and 10 being very stressed) ? **____/ 10**

How do you deal with your stress. What helps ?

_____

_____

What factors most contribute to your stress ?

Health Work Money Family Marriage Other

SYSTEMS STATUS

Digestion :

Stomach / upper tract : _____
(e.g.reflux, pain)

Colon / bowel motions
Colour of stools in general : _____
No of stools passed per day : _____
Consistency : _____
Diarrhoea/constipation : _____

Immunity :

Allergies : _____

Intolerances : _____

Self healing (recovery time !) : Good_____

Poor _____

Respiratory :

Ear, Nose & Throat : _____

Breathing : _____

Musculo-skeletal :

Spinal : _____

Joint mobility : _____

Posture :_____

Female sexual :

Length of cycle : _____
Painful/heavy periods _____
Cramps/menstrual irregularities _____
PMT ? : _____
Length of time on the PILL ? _____
Pregnancies : _____

Miscarriages/terminations : _____

Infertility ? : _____

Male sexual :

Libido : _____

Prostate : _____

Circulation : (Details taken in clinic)

Pulse : _____

Blood pressure : _____

Elimination :

Urination : _____

Skin : _____

Scalp : _____

List the medications you are currently taking, both over the counter and prescribed :

Medication	Dose/day	How long have you been on them ?
1		
2		
3		
4		
5		
6		

List all the supplements / homeopathics or herbal medicines you are currently taking :

Supplements	Dose/day	How long have you been on them ?
1		
2		
3		
4		
5		
6		
7		

List any adverse reactions you have had to any medication or supplements :

List any other treatments / therapies you are partaking of at the present time :

Briefly list your previous treatments and detoxification history:

How much do you eat/drink of the following :

	None	Very little	Moderate	Very much
Red meat				
Pork				
Fish				
Chicken				
Eggs				
Milk (cows)				
Cheese (cows)				
Yoghurt (cows)				
Butter				
Olive oil				
Refined sugary foods				
Pure Fruit juices				
Vegetables				
Fruit				
Fizzy drinks				
Salty foods				
Coffee				
Black tea				
Herbal tea				
Alcohol				
Wheat products, esp. breads				
Oats				
Barley				
Rye				
Soya products				

Alcohol : On average, how many units do you drink per week (1 unit = 1 standard glass of wine) ?
_____

What % of your diet would you say is organic ? _____

How often do you eat food cooked in a microwave ?_____

Check off the type of water you drink :

❑ Tap	❑ Filtered water	❑ Distilled
❑ Reverse osmosis	❑ Spring water	❑ Boiled

How many glasses of water do you drink in a day ? _____

If you drink bottled water what brand do you like ? _____

Do you smoke ? If so, how many a day ? _____

Are you exposed to passive smoke ? _____
If so, for approx how many hours per week ? _____
Have you ever been exposed to major environmental toxins ? If so explain.
_____
_____

Do you use a coal stove/fire (either regular or 'smokeless' coal), or do your neighbours use coal ?
_____

Do you have fluorescent lights in your kitchen or office ? _____

Do you have a computer or TV in your bedroom ? _____

Do you keep electrical appliances near your bed, e.g., a clock radio, lamp or phone ?
_____

Do you use a mobile phone ?_____**Frequency of use ?** _____

Is your regular phone usage low, moderate or high ? _____

Do you use any of the following ? : (please circle)

Electric blanket / Electric shaver / Electric toothbrush

Do you use a computer ? If yes, how many hours per day ?_____

If you watch TV how many hours per day ? _____

What type of heating do you have in your home ? _____

If you live in a house, which room do the power lines enter ?_____

Do you live near any of the following ? (Please circle) :

Pylons / a cellular tower / high power generator / crematorium / industrial zone / polluting factory / nuclear plant

DENTAL DETAILS

How many amalgam fillings do you have (i.e. any dental fillings which are silver or black – coloured) ?
_____

How long since the first one was placed ? _____

To your knowledge would your mother be likely to have had amalgam fillings before your birth ?

_____

And your father & Grandparents ? _____

How many gold caps, root canals or other dental restorations do you have ?
(please state which) _____

Have you ever had any amalgam fillings removed ?_____

If so, when ? _____

What safety procedures were used if any ? _____

Thank – you for taking the time to fill out this overview form.

This information will greatly assist me in helping you achieve your healthcare goals.

Please use this area and overleaf for writing anything else you feel is relevant in terms of your current or past health.

PLEASE NOTE : The information you provide on this medical assessment is confidential and will not be passed on to any third party without the consent of you the patient. It will not be stored on any device that would allow access to it via the internet.

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