Clinic of NaturalMedicine
where modern science meets ancient wisdom

Patient Medical Information Form

Date _____ **Surname** _____ **First name** _____
Address : _____
_____ **POST CODE** _____
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								
Parkinsons								
Other :								

Rate each of the following symptoms based upon your typical health profile by placing a tick on the line against each symptom that you generally present with.

Mouth

__Pain
__Lip ulcers
__Tongue ulcers
__Gum ulcers
__Cold sores
__Canker sores at side of mouth
__Bleeding gums
__Excess thirst
__Other

__TOTAL

Throat

__Pain
__Swellings/Goitre
__Chronic coughing
__Gagging/need to clear/mucousy
__Hoarseness
__Loss of voice
__Swallowing difficulties
__Other

__TOTAL

Digestive Tract

__Pain
__Acid reflux/heartburn
__Belching
__Flatulance
__Bloating
__Herniation
__Nausea
__Vomiting
__Food Intolerances
__Food Allergies
__Craving sugar
__Craving salt
__Craving other foods
__Binge eating
__Binge drinking
__Mucous in stools
__Blood in stools
__Diarrhoea
__Constipation
__Other

__TOTAL

Rectum

__Pain
__Rectal itching
__Hemorrhoids
__Anal fissure
__Other

__TOTAL

Weight

__Excess weight
__Underweight
__Water retention

__TOTAL

Head

__Headaches
__Migraine
__Faintness
__Dizziness
__Poor memory
__Brain fog
__Poor concentration
__Difficulty making decisions.
__Stuttering or stammering.
__Slurred speech
__Learning disabilities
__Poor physical coordination
__Other

__TOTAL

Mind/Emotions

__Depressed
__Anxious
__Stressed
__Fearful
__Nervous
__Angry
__Aggressive
__Irritabable
__Mood swings
__Panic attacks
__Other

__TOTAL

Skin

__Acne
__Hives/rash/Itchy
__Dry skin
__Eczema
__Psoriasis
__Hot flushes
__Excessive sweating
__No sweating at all
__ Scalp issues
__Other

__TOTAL

Energy
__Fatigue/sluggishness
__No motivation
__Hyperactivity
__Restlessness
__Other

__TOTAL

Heart
__Pain
__Irregular heartbeat
__Skipped heartbeat
__Palpitations
__Pounding heartbeat
__Low Blood pressure
__High Blood pressure
__Other

__TOTAL

Lungs
__ Chest congestion
__Asthma/Bronchitis
__Shortness of breath
__Other

__TOTAL

Kidneys/Urinary
__Frequent painful urination (Cystitis)
__Urgent urination
__Genital itching
__Discharge
__Nocturnal visits to the toilet
__Bedwetting (Enuresis)
__Other

__TOTAL

Ears
__Itchy
__Tinnitus
__Earaches/infections
__Drainage from the ear
__Flaky
__Blocked with wax
__Other

__TOTAL

Nose
__Sensitive to chemical smells
__Stuffy
__Sinus issues
__Hay fever
__Sneezing attacks
__Other

TOTAL

Eyes
__Watery
__Floaters
__Itchy
__Swollen
__Reddened
__Sticky
__Dark circles under
__Bags
__Blurred vsion
__Tunnel vision
__Partially sited
__Other

__TOTAL

Male
__Prostatitis
__Loss of Libido
__Other

__TOTAL

Female
The PILL
Length of time on the PILL _____
Type of PILL _____

Periods:
Length of cycle ____days

__Painful
__Heavy
__Cramps
__PMT

__Pregnancies
__Miscarriages
__Terminations
__Infertility issues ever
__Assisted fertility
__Loss of Libido

__TOTAL

Muscles & Bones
__Joint aches
__Muscle aches
__Stiffnes or limitation of movement
__Feeling of weakness in the muscles
__Recurrent back/neck/shoulder aches
__Numbness in extremities
__Burning in extremities
__Tingling in extremities
__Cold hands and feet
__Other

__TOTAL

Bowel motions:

Colour and consistency of stools in general:
__Pale grey
__Light brown
__Mid brown
__Dark brown
__Green
__Yellow
__Diarrhoea
__Constipation

No of stools passed per day: X ____________

Immunity:

True Allergies/serious reactions:
____
____
____
____

Intolerances:
____
____
____
____

Self-healing (recovery time if you cut yourself!)

__ Good
__ Poor

Circulation: (Check done in clinic)

Pulse : ______________________________
Blood pressure : ______________________

Other important irregularities to note
____
____

LIST OF SURGERY/HOSPITAL VISITS SINCE BIRTH with dates.

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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___ more___
In the past 5 years : 3x___4x___5x___6x___7x___8x___more ___
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.

GENERAL HEALTH :

Exercise routine _____

Sleep pattern _____

CURRENT STRESS

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 ?
_____
_____

List any deep trauma you have experienced in your life.
_____
_____
_____

What factors most contribute to your stress ?

Health Work Money Family Marriage Other

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		
7		
8		

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 and please give an example of what you eat in an average day:

	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				
Wheat products,esp.bread				
Oats				
Barley				
Rye				
Soya products				

Breakfast

_____

_____

_____

_____

Lunch

_____

_____

_____

_____

_____

Dinner

_____

_____

_____

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 ? _____

Toxicology check

Do you smoke ? If so, how many a day? _____
Are you exposed to passive smoke? _____
If so, for approx how many hours per week? _____
Do you or have you ever in the past smoked recreational drugs _____
Please list _____
Do you smoke e cigarettes?_____

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 ?

_____

EMF/Radiation/Electro pollutants check

Do you have a computer, lap-top, I pad, TV or mobile phone in your bedroom? Please circle.
Do you keep electrical appliances near your bed, e.g., a clock radio, lamp or phone? Please circle.
Do you use a mobile phone? _____
Is your regular phone usage low, moderate or high? Please circle.
Is your regular phone corded or cordless? _____
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? _____
Do you have broadband or Wi-Fi? Please circle.
If you have Wi-fi do you turn it off each time you have used it?____
If you watch TV, how many hours on average per day? _____
In your house where is the fuse box? _____

Do you have SMART meters on any of your Utilities ie Gas, Electric or Water?_____
If so for how long have they been installed?_____

How many x rays have you had in your life? _____
How many mammograms have you had in your life? _____
Have you had any of the following scans and how many?

__Ultrasound
__MRI
__CT
__CAT
__Other

Do you live near or used to live near any of the following? Please circle :

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

Mould check

__ Any mouldy premises at your previous work place?
__ Any mouldy premises at your current work place?
__ Any mouldy premises at your previous houses?
__ Any mouldy premises at your current house?

Dental details

How many of the following to your knowledge have you currently got?

___ Hg fillings (the dark grey ones)
___ Cavitations
___ Root canal fillings
___ Dentures
___ Crowns
___ Other

How many amalgam fillings did you have in the past but they have been replaced with white ones and when?
_____
What safety procedures were used if any? _____
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 how many?
_____
And your father & Grandparents? _____

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. This is in accordance with current Data Protection legislation.

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Best Naturopathic Clinic 2018- North West England
(Lux Health, Beauty & Wellness Awards)