



PATIENT CASE HISTORY

Date: ___/___/___ Referred By (eg. Another patient, yellow pages, signs) _____

SURNAME: _____ GIVEN NAMES: _____ Male / Female

ADDRESS: _____ POSTCODE: _____

TELEPHONE: (Home) – () _____ (Work) – () _____

EMAIL: _____

DOB: ___/___/___ AGE: ___ WEIGHT: ___ MARITAL STATUS: ___ No. of children: ___

OCCUPATION (Past & Present) _____

MAJOR COMPLAINT / what you seek help with _____

When did it start? _____

How often does it occur? _____

How long does it last? _____

What makes it better _____

worse _____

Other **SECONDARY COMPLAINTS** (describe, and when did they start?) _____

PAST medical problems / illness (from childhood onwards) _____

Any **OPERATIONS** (& approx how long ago) _____

PAST traumas / accidents / injuries / broken bones (& when) _____

ALLERGIES (Drug, Food, Chemicals) _____

VACCINATIONS (Past & Recent) – and any reactions? _____

Any foods that disagree with you? _____

Bowel Motions – How often? _____ **Liquid/Soft/Firm/Hard?** _____

Past Constipation/Diarrhea/blood in stools/mucous in stools? _____

Sleep patterns – sound or broken, time to bed, time to wake? _____

Dreams – many / few remembered / pleasant / unpleasant? _____

Emotional State (eg. Stressed / anxious / chronic worrier / panic attacks / depressed / restless / irritable / relaxed / happy / easy going) _____

Energy Levels – low / medium / high? _____

Hobbies/interests/sports/exercise in recent times _____

Medications (including vitamins, Panadol, laxatives, the Pill) – include dose, and when began taking approx _____

PAST medications _____

Family medical history (parents, grandparents, aunts, uncles, brothers, sisters) e.g. heart problems, diabetes, stroke, high blood pressure, asthma, epilepsy, cancer, depression, migraines, ulcers etc _____

Your AVERAGE Day's Diet: (Also list brown or white bread and what sandwich fillings)

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>
_____	_____	<i>Times per wk</i> – Red meat _____	_____
_____	_____	Chicken _____	_____
_____	_____	Fish _____	_____
_____	_____	Vegies _____	_____
_____	_____	Salad _____	_____
_____	_____	Pasta _____	_____
_____	_____	Rice _____	_____
_____	_____	Others _____	_____
_____	_____	_____	_____
_____	_____	Dessert _____	_____

PER DAY – Coffee _____ Cups (Milk/Sugar) Tea _____ Cups (Milk/Sugar) Herbal Tea _____

Water _____ Glasses Alcohol (type & amount) _____ Cigarettes _____

Other Recreational Drugs _____

DO / DID you ever have:

PLEASE TICK	OFTEN	SOMETIMES	NEVER	COMMENTS
Shortness of breath				
Chest pain				
Palpatations/Heart Races				
Swollen Feet				
Cough				
Phlegm / Sputum				
Hayfever				
Sinus Problems				
Stomach Bloating				
Wind – Burps				
- Flatulence				
Poor Appetite				
Excessive Appetite				

Sweet cravings				
Heartburn				
Abdominal Pain				
Weight gain				
Weight Loss				
Jaundice (Yellow skin)				
Burning when passing urine				
Frequency of urine				
Difficulty in passing urine				
Poor bladder control				
Sore tongue				
Mouth ulcers				
Very easy bruising				
Lumps that concern you				
Headaches				
Poor eyesight/eye problem				
Poor hearing				
Numbness of tingling of hands/feet				
Cramps in feet or legs				
Been unconscious				
Skin rashes, dermatitis or Eczema				
Painful joints				
Still joints				
FEMALES – Painful period				
Heavy periods				
Bleeding between periods				
P.M.T.				

Usual cycle length = _____ days, Lasts _____ days, Flow = Light / Moderate / Heavy? _____

Date of last period _____

Number of pregnancies _____ Any problems? _____ Type of birth _____

Goals of Visit/Other Concerns
