# 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) _____

_____
_____
_____
_____

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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 _____

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_____
_____
_____
_____

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

| **Breakfast** | **Lunch** | **Dinner** | **Snacks** |
|---|---|---|---|
| _____ | _____ | *Times per wk* – 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 | | | | |

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| | | | | |
|---|---|---|---|---|
| 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

_____
_____
_____
_____
_____

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