



# Jade Mountain Medicine Patient Health History

Date \_\_\_\_\_

Name \_\_\_\_\_  
(First) (Last)

Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

E-mail: \_\_\_\_\_

Are you currently receiving health care? Y N

If yes, where and from whom? \_\_\_\_\_  
\_\_\_\_\_

## Condition

## Past Treatment

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking: (add a page if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Height \_\_\_\_\_ Weight \_\_\_\_\_ Past Max. Weight \_\_\_\_\_ When? \_\_\_\_\_

Blood Pressure: What is your most recent blood pressure reading? \_\_\_\_\_

When was this taken? \_\_\_\_\_

Do you have any reason to believe that you are pregnant? Y N

Do you have any infectious diseases? Y N If yes, please explain:

\_\_\_\_\_

Are you currently suffering from any chronic illness? Y N If yes, please explain:

\_\_\_\_\_

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include any type of reaction)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### General Condition

Energy Level:  Low  High  Erratic  Loss of Energy  Other

Any tendency to faint, bruise or bleed easily? Y N

### Hospitalizations and Surgeries

Reason	When	Reason	When
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### X-rays / CAT Scans? MRIs / NMRs / Special Studies? (add page if necessary)

Reason	When	Reason	When
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



<b>FAMILY HISTORY</b>	<b>Mother</b>	<b>Father</b>	<b>Brothers</b>	<b>Sisters</b>	<b>Spouse</b>	<b>Children</b>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

**Lifestyle**

Please indicate typical food intake:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Daily Exercise \_\_\_\_\_

Sleep Habits \_\_\_\_\_

Education \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Hrs./wk. \_\_\_\_\_

Do you enjoy work? Y N Why/Why not?  
\_\_\_\_\_

Nicotine / Alcohol / Caffeine use \_\_\_\_\_

Have you experienced any major traumas? Y N  
Explain \_\_\_\_\_  
\_\_\_\_\_

Consumption of Liquids \_\_\_\_\_

Television Habits \_\_\_\_\_

Reading Habits \_\_\_\_\_

Interests and Hobbies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



#### GENERAL SYMPTOMS

- Tremors
  - Headache
  - Fever
  - Sweats
  - Fainting
  - Dizziness
  - Convulsions
  - Loss of sleep
  - Fatigue
  - Nervousness
  - Depression
  - Loss of weight
  - Forgetfulness
  - Numbness or pain in arms, hands, elbows, shoulder, hips, legs, knees, or feet
  - Confusion
  - Auto Immune Deficiency
  - Paralysis
- #### EAR, NOSE & THROAT
- Failing vision
  - Nearsighted
  - Eye pain
  - Eye strain
  - Cross-eyed
  - Eye inflammation
  - Glaucoma
  - Deafness
  - Earache
  - Loss of hearing
  - Ear discharge
  - Ear noises
  - Nose bleeds
  - Nasal obstruction
  - Nasal drainage
  - Loss of smell
  - Sinus infection
  - Hay fever
  - Allergies
  - Sore throat
  - Hoarseness
  - Difficult speech
  - Difficult swallowing
  - Loss of taste
  - Change in tastes
  - Dental decay
  - Gum troubles
  - Tonsillitis
  - Asthma
  - Enlarged thyroid

#### SKIN

- Skin eruptions
- Clammy Skin
- Dryness
- Bruise easily
- Boils
- Rashes
- Sensitive skin
- Hives or allergy

#### RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing
- Wheezing

#### CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- Irregular beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Varicose veins

#### MUSCLE & JOINT

- Stiff neck
- Pain between shoulders
- Backache
- Painful tail bone
- Foot trouble
- Hernia
- Spinal curvature
- Faulty posture
- Swollen joints
- Stiff joints
- Painful joints
- Arthritis
- Sore muscles
- Weak muscles
- Walking problems
- Sciatica

#### GENITOURINARY

- Frequent urination
- Scanty urine
- Painful urination
- Pus in urine

- Bed wetting
- Inability to control urine
- Bladder trouble
- Foul smelling urine
- Discolored urine

#### GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Difficult chewing
- Belching or gas
- Nausea
- Gas
- Vomiting
- Vomiting of blood
- Pain over stomach
- Distention of abdomen
- Constipation

- Diarrhea
- Black stool
- Blood in stool
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis
- Weight trouble

#### FEMALE

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Vaginal pain
- Congested breast
- Breast pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding
- Reduced sexual energy
- Pregnancy
- Pregnancy complications

#### MALE

- Pain associated with genitals
- Reduced sexual energies
- Premature ejaculation
- Seminal emission
- Impotence