



### Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: cell, work, home: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F Marital status: S M D W

Emergency Contact Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Emergency Contact # \_\_\_\_\_

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Please identify the health concerns that have brought you to the Tamara TCM office in order of importance below:

**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? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

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

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?    Y    N    If yes, please identify: \_\_\_\_\_

**8. Family History:**                      Father                      Mother                      Brothers                      Sisters                      Spouse                      Children

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_    **Weight:** Currently: \_\_\_\_\_    Past Maximum: \_\_\_\_\_    When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_    When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever    Diphtheria    Rheumatic Fever    Mumps    Measles    German Measles    Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio    Tetanus    Rubella/Mumps/Rubella    Pertussis    Diphtheria    Hib    Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

15. Do you have a cardiac pacemaker or other internal electronic device?    Y    N    If yes, please identify: \_\_\_\_\_

16. Do you have a history of epilepsy or seizures?    Y    N    If yes, please explain: \_\_\_\_\_

17. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                      Nervousness/Anxiety                      Mental Tension                      Depression

18. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue                      Slow Wound Healing                      Chronic Infections                      Chronic Fatigue Syndrome

19. **Head, Eye, Ear, Nose, & Throat** (please circle any that you experience now & underline any that you have experienced in the past):

Impaired Vision                      Eye Pain/Strain                      Glaucoma                      Glasses/Contacts                      Tearing/Dryness

Impaired Hearing                      Ear Ringing                      Earaches                      Headaches                      Sinus Problems

Nose Bleeds                      Frequent Sore Throats                      Teeth Grinding                      TMJ/Jaw Problems                      Hay Fever

20. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                      Frequent Common Colds                      Difficulty Breathing                      Emphysema

Persistent Cough                      Pleurisy                      Asthma                      Tuberculosis

Shortness of Breath                      Other Respiratory Problems: \_\_\_\_\_

21. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                      Chest Pain                      Swelling of Ankles                      High Blood Pressure

Palpitations/Fluttering                      Stroke                      Heart Murmurs                      Rheumatic Fever                      Varicose Veins

22. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers                      Changes in Appetite                      Nausea/Vomiting                      Epigastric Pain                      Gas                      Heartburn

Belching                      Gall Bladder Disease                      Liver Disease                      Hepatitis B or C                      Hemorrhoids                      Abdominal Pain

What did you eat yesterday? \_\_\_\_\_

What did you eat today? \_\_\_\_\_

How many bowel movements per day? \_\_\_\_\_ Do you tend toward constipation, loose stools, or diarrhea? \_\_\_\_\_

23. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                      Painful Urination                      Frequent UTI                      Frequent Urination                      Heavy Flow

Kidney Stones                      Impaired Urination                      Blood in Urine                      Frequent Urination at Night

24. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                      Breast Lumps/Tenderness                      Nipple Discharge                      Heavy Flow

Vaginal Discharge                      Premenstrual Problems                      Clotting                      Bleeding Between Cycles

Menopausal Symptoms                      Difficulty Conceiving                      Painful Periods                      Low libido

25. **Menstrual/Birthing History (continued on back):**

1. Age of First Menses: \_\_\_\_\_                      2. Day of your cycle: \_\_\_\_\_                      3. Length of Cycle: \_\_\_\_\_

4. # of Days of Menses: \_\_\_\_\_ Color of blood \_\_\_\_\_                      5. # of Pregnancies: \_\_\_\_\_                      6. # of Live Births: \_\_\_\_\_

7. # of Abortions: \_\_\_\_\_

8. # of Miscarriages: \_\_\_\_\_

9. Birth Control Type: \_\_\_\_\_

26. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties

Prostrate Problems

Low Libido

Testicular Pain/Swelling

Penile Discharge

27. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain

Muscle Spasms/Cramps

Arm Pain

Upper Back Pain

Mid Back Pain

Low Back Pain

Leg Pain

Joint Pain (if so, where?): \_\_\_\_\_

28. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness

Paralysis

Numbness/Tingling

Loss of Balance

Seizures/Epilepsy

29. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid

Hypoglycemia

Hyperthyroid

Diabetes Mellitus

Night Sweats

Feeling Hot or Cold

30. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia

Cancer

Rashes

Eczema/Hives

Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

31. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

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

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

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

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to receive our email newsletter? \_\_\_\_\_