



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Male  Female

Mobile Phone: \_\_\_\_\_

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

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

Married  Single

Number of Children: \_\_\_\_\_

Your Nationality: \_\_\_\_\_ Occupation: \_\_\_\_\_

Post Number: \_\_\_\_\_

Address: \_\_\_\_\_

Please indicate how you heard about our clinic and tell us the name of your source.

\_\_\_\_\_

<Pregnancy>Your estimated delivery date: \_\_\_\_\_

Place: \_\_\_\_\_

### < ABOUT YOUR SYMPTOM NOW >

What is your symptom? \_\_\_\_\_

When did it start? \_\_\_\_\_

What do you think is the cause? \_\_\_\_\_

Did you consult a doctor or other clinic before?

No /  Yes ①Department: \_\_\_\_\_

②Diagnosis: \_\_\_\_\_

③Details of treatment: \_\_\_\_\_

☞ Medicine/Herbal medicine

None /  Yes(Name/Effect): \_\_\_\_\_

☞ Physical examination

Did not take /  Within normal range /  Abnormal: \_\_\_\_\_

### < YOUR HISTORY >

☞ Disease/Problems

Never /  I had(When/Diagnosis): \_\_\_\_\_

☞ Accident / Injury

Never /  I had(When): \_\_\_\_\_

☞ Surgery

Never /  I had(When/Hangover): \_\_\_\_\_

I understand that I am financially responsible for the services that receive at SHC. I will satisfy my obligation in cash. Also, I hereby authorize the physician to treat me ( or my dependent / minor child ).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
( or Patient's Parent / Guardian, if Minor )

### CONFIDENTIAL HEALTH HISTORY

In the space in front of each item, please draw "O" if you HAVE the problem now, or draw "Δ" if you have HAD the problem.

#### GENERAL

- Fever
- Chills
- Night Sweats
- Loss of Sleep
- Fatigue
- Nervousness
- Weight Loss or Gain
- Allergies
- (Name: \_\_\_\_\_ )
- Bleeding Problem
- Anemia
- Diabetes
- Cancer (Name: \_\_\_\_\_ )
- Thyroid Disease
- Goiter
- Alcoholism
- Drug Abuse

#### EYE EAR NOSE THROAT

- Poor Vision
- Pain in Eye(s) (Right/Left/Both)
- Deafness/Difficulty Hearing (Right/Left/Both)
- Nosebleeds
- Nose Problems
- Sinus Problems
- Dental Problems
- Hoarseness
- Tonsillectomy

#### GASTROINTESTINAL

- Poor Appetite
- Poor Digestion
- Difficulty Swallowing
- Belching or Gas
- Frequent Nausea
- Vomiting
- Vomiting Blood
- Pain over Abdomen
- Ulcer
- Black or Bloody Stools
- Liver Problems
- Gall Bladder Problems
- Jaundice
- Hernia
- Diarrhea
- Constipation
- Hemorrhoid
- Appendicitis

#### NEUROLOGIC

- Weakness
- Twitching
- Tremors
- Headache
- Fainting
- Dizziness
- Convulsing
- Epilepsy
- Numbness/Tingling
- Arm/Leg Pain
- Mental Disorder

#### RESPIRATORY

- Difficulty Breathing
- Chronic Cough
- Spitting Phlegm
- Spitting Blood
- Wheezing/Asthma
- Pneumonia
- Tuberculosis

#### CARDIOVASCULAR

- Irregular Heartbeat
- High Blood Pressure
- Pain over Heart
- Previous Heart Trouble
- Ankle Swelling
- Varicose Veins
- Rheumatic Fever
- Stroke

#### GENITOURINARY

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Disease
- Urinary Infection
- Inability to Control Urination
- Difficulty Starting Urine Flow
- Get up \_\_\_\_\_ times per
- Night to Urinate
- Venereal Infection
- Sexual Difficulties

#### SKIN

- Itching
- Bruising Easily
- Change in Mole(s)
- Skin Cancer

#### MUSCULOSKELETAL

- Neck Stiffness/Pain
- Pain Between Shoulders
- Low Back Pain
- Swollen Joints
- Painful Joints
- Muscle Aches/Soreness
- Spinal Curvature
- Arthritis

#### MEN ONLY

- Testicular Swelling/Pain
- Prostate Problems

#### WOMEN ONLY

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Vaginal Burning/Itching
- Hot Flashes
- Date Last Period Began \_\_\_\_\_

Date of Last PAP Test \_\_\_\_\_

Breast Lump or Pain \_\_\_\_\_

#### HABITS

- Smoking \_\_\_\_\_ Packs/day
- Drinking \_\_\_\_\_
- Recreational Drug Use \_\_\_\_\_

#### EXERCISE

- None
- 1-2 times/week
- 3-5 times/week
- 6-7 times/week

#### FAMILY HISTORY

Include, information on brothers, sisters, parents and grandparents. DO NOT INCLUDE YOURSELF.

- Diabetes ( \_\_\_\_\_ )
- Thyroid Disease/Goiter( \_\_\_\_\_ )
- Tuberculosis ( \_\_\_\_\_ )
- Kidney Disease ( \_\_\_\_\_ )
- High Blood Pressure( \_\_\_\_\_ )
- Heart Disease ( \_\_\_\_\_ )
- Muscle, Bone or Nerve( \_\_\_\_\_ )
- Cancer( \_\_\_\_\_ )

①Height      cm    ②Weight      kg    ③Blood Pressure      /      mm/Hg    ④ Left-hander • Right-hander

# Family tree

Please write first name, last name and age into ( ). Please explain about his or her personality and impressive memories you have.

Example : 1.He loved me until I was 5 years old. (Tom Suto 75YO) **Father** — **Mother** (Ann Suto 65YO) 1. Bright, caretaker.  
 2.He quit his job when he was 38 years old. 2. Past away 1995.  
 His personality changed. He became more regid.



