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)

_____ _____

_____ _____

_____ _____

_____ _____

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JADE MOUNTAIN MEDICINE

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
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

JADE MOUNTAIN MEDICINE

FAMILY HISTORY —	Mother	Father	Brothers	Sisters	Spouse	Children
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 _____

_____

_____

JADE MOUNTAIN MEDICINE

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