What is the main problem? Since when have you had this?

Have you had any medical treatment for this?

Clinical history. (What illnesses have you had in the past?)

Are you taking medications or supplements now?

Are you allergic to anything?

Have you ever had harmful side effects from medications?

Physique : athletic underweight average overweight

Blood pressure : highest_____ lowest_____

Constitution : tire quickly chilliness sensitive to cold sensitive to heat
dizziness other( )

Perspiration : rare often whole body only the upper body
face only head only night sweats sudden sweats dripping

Excrement : How often do you have bowel movements?_____
Smoothly(Yes / No) constipation too loose
a feeling some is left too thin too soft
indigestion excessively odorous too like mud too hard balls
loose bowels and constipation alternately
use constipation medicine (Yes / No)

Urine : How often do you urinate?_____
How often do you urinate at night?_____
Color is (dark yellow, yellow, brown, colorless)
perfectry out a feeling some is left not smoothly painful

Water : intake about_____ml a day
thirsty dry mouth dry lips insatiable thirst

Tongue : coated moss(Yes / No) Color is(white, yellow, red, brown) painful

Mouth : bitter taste vomit taste want some drinks for thirst
thirsty, but do not want to drink much saliva bad breath
constricted throat

Period : intervals____days changeable pain(hard, slight, none) periods____days
blood lump(Yes / No) vaginal discharge(heavy / light)
Menopause_____age_____

Hand : cold flush hot sweat

Leg : cold flush hot sweat

Sore shoulder : sore very sore painful

Chest and side : feel pressure general chest pains difficult breathing
fast heart rate wheezing sharp pain

Stomach : appetite (Yes / No)
blocked pain feel sick want to vomit belching gas

Bowels : audible sounds feeling of fullness sense of movement painful
cold feeling

Nerves : easily surprised quick tempered very irritable depressed paranoia

Whole body : slight fever chills chills and fever alternately feel bad wind
trouble sleeping have many dreams light headedness
always sleepy swollen(where_____) back ache head ache
dizziness

Others :

Height_____cm Age_____Occupation_____ E-mail add._____
Weight_____kg Address〒_____
Name_____ Tel_____