

Name:	Sex:	Age:	Height:	Weight:	Job:
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Chief complaint :	Blood pressure /
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Current Medications :

Please mark in each which best describes your symptoms

Appetite, Tastes	
Have a good appetite (Eat any kind of food Tend to overeat frequently)	Have a poor appetite
Can't stand being hungry	Feel full even with a small meal
Have gained body weight recently	Have lost body weight recently
Tastes you like (Sweet Spicy Bitter Sour Salty Meat Vegetables)	
Smoke (Duration : _____years / _____packs a day)	
Drink alcohol (_____ times per week/ _____glasses per time)	

Digestion	
Digest well	Digestive problems (Poor digestion always Poor digestion now and then)
Burp frequently	Often feel food blocking in the upper abdomen after meals
Throw up on and off	Gurgling sound from your stomach often
Have a nausea frequently	Bloating or gas in the bowels Gagging on tooth-brushing
Have stomachache frequently(On an empty stomach After eating With stress)	

Thirsty		
How much liquid(water, tea, soda, milk, coffee and etc) do you take a day? _____glasses(8oz)		
Reasons for drinking (Thirsty To stay healthy Out of habit)		
Prefer cold drink	Prefer hot or warm drink	My lips or mouth get dry often
Guzzle lots of water(I can drink up a glass of water at once)		Take a small sip
Hard to tolerate a thirst	Feel thirsty easily when I get hot	Can't have a meal without drinks

Bowel movement	
How often? _____time(s) per _____day(s)	
Feel relieved after bowel movement	Don't feel completely relieved after bowel movement
Need make a bowel movement every day	Feel ok without bowel movement for a few days
My stool is quite hard	My stool is loose(it loses its shape in the toilet)
Have diarrhea frequently	The color of my stool is(Golden Black Brown)
Sometimes see blood in the stool	Sometimes see undigested foods in the stool
Gas in the lower abdomen frequently	Tend to have diarrhea with cold foods
Suffer from constipation	Take supplements to help a bowel movement

Don't think too much. Just check what comes right away in your mind

Urination		
What is your frequency of urination during daytime? times daytime		
What is the color of your urine? Clear Lemonade color Yellow Dark yellow or _____		
Feel my bladder empty after urinating	Feel my bladder holding some urine after urinating	
Have a urination in the middle of night (_____times per night)	Hard to hold urine	
Often find that underwear gets slightly wet after urinating	Hard to pass urine	
Have pain while/after urinating	Have a small amount of urine	Have a dribbling of urine

Sweating		
Sweat easily	Hardly sweat	Night sweats
Feel good after sweating	Feel tired after sweating	Don't like sauna
Sweat only when exercise hard or during sauna		
Sweat only on some parts of my body(Face Chest Neck or back Palms Feet or _____)		

Body Temperature		
Can't stand hot	Don't like the cold air from air-conditioner	Can't stand cold
Feel hot and cold at the same time on some parts of my body		Get flushed easily
I have the alternation of hot and cold(Hot and cold comes and goes one after another)		
Feel feverish on some parts of my body (Where : Face Hands Feet / When : When tired Any time At night)		

Head and Face	
Frequent Headache(Migraine) (When _____/ How : _____)	
Feel dizzy on and off(When : _____)	Lose my balance of legs all of a sudden
Have swollen glands or tonsillitis on and off	Canker sore frequently
Often feel something stuck in my throat	Catch cold more on changing season
have respiratory complaints frequently (Cough Sneeze Nasal mucus Nasal congestion)	
Often Have phlegm (Watery and easy to spit out Sticky and hard to spit out)	

Chest		
Palpitation(fast heart-beat) on and off		Sometimes have a stuffy/tight chest
Have shortness of breath when walking or running		Tend to sigh often
Hard to breathe in	Hard to breathe out	Feel mentally unstable on and off
Have hiccups once in a while		Often feel stiff or sharp pain in my chest
Avoid wearing tight fitting underwear, neckties or clothes due to discomfort		

Sleep	
Sleep well	Hard to fall asleep
Take sleeping pills or sedative	Yawn frequently
Feel refreshed when waking up in the morning	Tired when waking up in the morning
Wake up in the middle of night and hard to go back to sleep	
Feel muzzy for a while after waking up in the morning	
Drinking coffee irritates me (ex: palpitation, sleeping problem, shaking body or hands)	

Limbs, Body, Skin		
Warm limbs (hands feet)	Cold limbs (hands feet)	Limbs tingle sometimes
Limbs get stiff sometimes	Cramp in legs sometimes	Bruise easily
Frequently have a general body-ache when tired	Feel numb somewhere on my body	
Muscle-twitching when tired, nervous or stressed	Often have skin-eruption caused by foods	
Puffy or swollen(where: Whole body Face Hands Legs or feet /		
When: In the morning In the evening All day long)		

Joint problems			
Neck	Shoulder	Elbow	Wrist
Fingers	Hip joint	Knee	Ankle
Toes	Upper back	Low back	Sacrum
Have swollen joints		Have pain worse with cold	

Female only	
Number of delivery _____time(s)	Number of abortion/miscarriage time(s)
Menopausal since _____years old	Forget something easily
Regular period (Every_____days)	Irregular period
Strong appetite before period	Irritated before period
Vaginal discharge (what color: Yellow White Vaginal itch)	
Suffer with cramps on period(It lasts _____hours / where: Lower abdomen Lower back Headache Other _____)	

Male only		
Poor erectility	Premature ejaculation	Wet dreams