

# Personal Medical Record

Date \_\_\_\_\_

Woman  Man

Date of birth: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ ID number \_\_\_\_\_

Surname \_\_\_\_\_ Christian name(s) \_\_\_\_\_

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

Postal code \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_

Phone no.: Home \_\_\_\_\_ Work \_\_\_\_\_

Next of kin \_\_\_\_\_

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

Postal code \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_

Phone no.: Home \_\_\_\_\_ Work \_\_\_\_\_

**Current main complaint/illness** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**Prescribed medicines or other conventional treatment followed?**

\_\_\_\_\_

**Current medication and dosage?** \_\_\_\_\_

\_\_\_\_\_

**Result of the treatment?** \_\_\_\_\_

\_\_\_\_\_

**Known allergy to drugs?** \_\_\_\_\_

\_\_\_\_\_

**Give details of any alternative therapy administered; treatment, medicine, vitamins, minerals etc.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Result of the therapy?** \_\_\_\_\_

\_\_\_\_\_

**Earlier illnesses?** \_\_\_\_\_

\_\_\_\_\_

**Earlier stay in hospital, year and illness/reason?** \_\_\_\_\_

\_\_\_\_\_

**Present work or occupation and any previous ones** \_\_\_\_\_

\_\_\_\_\_

**Any instances of following conditions in family?**

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Rheumatism, fibromyalgia |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Psoriasis                |
| <input type="checkbox"/> Struma (goitre or thyroid problems) | <input type="checkbox"/> Asthma, allergy, eczema  |
| <input type="checkbox"/> Heart or circulatory problems       | <input type="checkbox"/> High blood pressure      |
|  | <input type="checkbox"/> Low blood pressure       |

*The following questions apply to the last two years:*

**Digestion and bowel habits?**

- |  |  |
|--|--|
| <input type="checkbox"/> Daily excretion   | <input type="checkbox"/> Flatulence            |
| <input type="checkbox"/> No. of excretions per week _____  | <input type="checkbox"/> Gall bladder pressure |
| <input type="checkbox"/> Diarrhoea? If so; <input type="checkbox"/> yellow <input type="checkbox"/> brown <input type="checkbox"/> other |  |
| <input type="checkbox"/> Blood in stools   |  |

**Diabetes, type** \_\_\_\_\_

**Dental treatment for oral galvanism. When?** \_\_\_\_\_

Describe any changes in your health subsequent to the treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If not, do you have dental work consisting of;

- Amalgam fillings       Gold       Crowns       Bridges

**Have you suffered from recurrent infections?**

- Pneumonia, Year \_\_\_\_\_
- Arthritis, Year \_\_\_\_\_
- Cystitis, Year \_\_\_\_\_
- Abdominal inflammation, Year \_\_\_\_\_
- Tonsilitis, Year \_\_\_\_\_
- Otitis, Year \_\_\_\_\_
- Sinusitis, Year \_\_\_\_\_
- Other \_\_\_\_\_

**Have you suffered from...**

- Vaginal thrush or similar mycosis, Year \_\_\_\_\_
- Ringworm or similar, Year \_\_\_\_\_
- Hair rash, Year \_\_\_\_\_
- Anal pruritus, Year \_\_\_\_\_
- Dermatitis, Year \_\_\_\_\_
- Mouth ulcers, Year \_\_\_\_\_
- Shingles, Year \_\_\_\_\_
- Glandular fever, Year \_\_\_\_\_

**Menstruation?**

Time from onset to first day of following period: \_\_\_\_\_

- Irregular

Bleeding:

- Little
- Clotted and dark
- Heavy
- Painful

Pain during part of menstrual cycle?

- Before
- After

Do you use or have you used contraceptive pills?

- Yes during the period \_\_\_\_\_
- No

**Prostate gland?**

- No problems
- Need to pass water at night
- Dribbling
- Frequency
- Initial difficulty in passing water

**Do you have problems with...**

- Back ache
- Prickling/numbness
- Aching joints
- Headaches and migraine?  
Which part of head? \_\_\_\_\_
- Aching muscles

Do you  smoke  take snuff

Alcohol consumption? \_\_\_\_\_

Your height \_\_\_\_\_

Your weight \_\_\_\_\_

**Give as complete answers as possible:**

	Yes	No
Fit, no symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Minor symptoms of illness	<input type="checkbox"/>	<input type="checkbox"/>
Near normal activity, daily symptoms of illness	<input type="checkbox"/>	<input type="checkbox"/>
Need extra periods of rest every day	<input type="checkbox"/>	<input type="checkbox"/>
Need daily help with personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Special care and help needed (brief details below)	<input type="checkbox"/>	<input type="checkbox"/>

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

Hospital care essential. Fully supportive treatment and care needed	<input type="checkbox"/>	<input type="checkbox"/>
Mechanical aids needed (wheelchair etc.)	<input type="checkbox"/>	<input type="checkbox"/>

**If you wish to add any further details of your sickness please enter these below:**

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

Preferred time for treatment \_\_\_\_\_