To: OPTIMUM HEALTH CENTER

I,_____ (ID/PPT#_____), understand that Dr. Yuan Tai Ming, Alexander, who is the clinic director of Optimum Health Centre, has been qualified as Doctor of Chiropractic in Canada from Canadian Memorial Chiropractic College in 1982; as Doctor of Naturopathy in Canada from Ontario College of Naturopathic Medicine in 1986; and received the Diploma in Homeo-Therapeutics (D.HT) from Bengal Allen Medical Institute in India in 1987. Dr. Alexander Yuan is the vice-president of the Asian Homeopathic Medical League and is the vice-president and consultant of the World Federation of Chinese Naturopathy.

I also understand that, Dr. Alexander Yuan, Homeopath / Naturopath / Registered Chiropractor / Listed Chinese Medicine Practitioner, is not registered as an Allopathic medical practitioner under the Medical Registration Ordinance (Chapter 161) section 14 and 14A in Hong Kong.

All the products provided by Optimum Health Centre are for the promotion of health only. None of the products is for use in:

(a) the diagnosis, treatment, mitigation, alleviation or prevention of disease or any symptom thereof;
(b) the diagnosis, treatment, mitigation, alleviation of any abnormal physical or physiological state or any symptom thereof;
(c) altering, modifying, correcting or restoring any organic function,

in human beings or in animals.

_____ Date _____

Patient's signature

Purpose for consultation:

☐ **Just look after the existing health concern**

☐ **To improve myself constitutionally as a whole**

☐ **Anti-aging to achieve optimum health**

Indicate your general feeling well-being at this moment,
(worst: 0 ⇔10: best): ____

大 康 自 然 健 康 中 心
OPTIMUM HEALTH CENTRE

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Homeopathic Case Record

No.: **Date:**

Name: **Age:**

Sex: _____ **Date of Birth:** _____**yr**_____**mth**_____**day**

Birth Time: _____**hr**_____**min (AM / PM)**

H.K.I.D. No.: _____ **Occupation: (Nature of Work)**

_____

Telephone No.: **Address:**

Home- **Flat/Room** _____ **Floor** _____ **Block** _____

Office- **Building** _____

Mobile- **No.** _____ **Street/Road** _____

Fax- **District** _____

Country _____

Postal Code _____

Referred by: **Email:** _____

I would like to receive newsletter from :

☐ **Optimum Health Centre**

☐ **Sourcewadio.com**

In what language :

☐ **Chinese**

☐ **English**

採用：自然療法、脊骨神經科、同類療法、針炙、營養療法、按摩、芳香療法、水療、浣腸療法、草藥療法、電腦測試及各類健康用品食物、書籍等。

Practice of: Naturopathy, Chiropractic, Homeopathy, Acupuncture, Nutrition, Massage, Aromatherapy, Hydrotherapy, colonics, Herbalogy, Computerized Therapeutic Testing, Various Health Products, Food, Books, etc.

(Confidential)

*** (Please read each question carefully and then give your considered answers)**

MAIN COMPLAINT AND OTHER ASSOCIATED TROUBLES: (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES)

- ORIGIN OR CAUSE: Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, exposure to cold, heat etc.)

Mention the other following details of your health. Describe particularly and in detail ALL THE CHANGES OR STRANGE SYMPTOMS NOTICED after the onset of the present illness. Omit nothing. Try to describe the EXACT LOCATION and EXACT SENSATION of each complaint and the VARIOUS FACTORS AND CIRCUMSTANCES WHICH INCREASE OR DECREASE each trouble.

- Do you ever feel faint? If so, under what circumstances?
- Do you have giddiness? If so, describe how and when it is worse?
- Have you anything to complain about your head?
- Do you get headaches? If so, describe in detail when it comes, how it increases, where it starts and spreads etc. (mention if you have any trouble with your:)
    - Eye or Vision:
    - Ears or Sense of hearing:
    - Nose or Sense of smell:
    - Face or Facial expression:
    - Mouth or Sense of taste:

        Is there Dryness or Salivation?

        Tongue: (Describe its appearance)

            Is there any crack, indention, trembling etc.?

            If coated, describe colour and nature of coating:

        Teeth:

        Lips

        Gums, e.g. bleeding:

        Throat or Swallowing (including tonsils)

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*When answering the questions GIVE MAXIMUM POSSIBLE INFORMATION INCLUDING ALL DETAILS. If the space provided for the answers is insufficient write on a separate paper and attach. Describe particular ALL PECULIARITIES you might have noticed about yourself. Remember the prescription depends upon the fullness and correctness of the information you give?

APPETITE: What particular foods or drinks do you strongly crave for or you are strongly averse to: e.g. salty, sour, hot chilli, sweet, savory food, milk, eggs, fatty and fried food, cold drinks, coffee, tea, alcohol etc.?

How hungry do you feel: less, normal or unbearable? And what time?

What is the quantity of food you take now; same as, less or more than your original?

Is there any trouble after food; such as pains, burning, heaviness, sleepiness etc.?

THIRST: How much water do you take at a time and how many times in a day?

Do you prefer warm, ordinary, cold or iced?

ABDOMEN: Do you have bloating of abdomen? If so, when?

Do you pass gas? Up or down? Does it give relief?

RECTUM & ANUS: Is there any pain, burning, prolapse, piles, etc.?

If so, is it more before, during of after stool?

STOOLS: How many times do you pass?

Mention the quantity, colour and consistency.

Has it any bad smell?

URINE: Mention frequency, quantity, colour, smell etc.;

Any difficulty in passing? Is the flow slow to start, interrupted, feeble, dribbling etc.?

Do you find it easier to pass in any particular position?

How often do you pass at night?

Any involuntary urination?

Is there burning? If so, is it worse before, during or after urination?

SEXUAL SPHERE: Have you Excessive desire, Aversion etc.?

Do you suffer from sexual disturbances?

Do you suffer in any way after intercourse? If so, describe how.

For Men:

Do you have night emission?

Any inability to perform or quick ejaculation?

For Women:

Menses: How are the periods; regular or irregular?

At what age did it start? Was there any trouble then?

Mention interval between and No. of days of flow:

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

If the menses have stopped, state how you feel after that.

Do you suffer in any way before, during or after Menses? If so, describe:

Do you feel better or worse, during or after the Menses?

Do you feel the internal parts coming down?

Is there any leucorrhoeal (white) discharge?

If so, mention the nature, colour, consistency and smell of the discharge and when and under what circumstances it is more or less.

Do you catch cold often? If so, how?

Is there any trouble in your chest or heart?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

If so, when, in which position and under what circumstances is it worse?

Do you have cough?

Describe when and under what circumstances the cough is worse.

Is it dry or moist? Describe the nature of the sputum if any.

Do you have any trouble in your back, limbs or joints? Describe in detail.

If you have any pains, do they shift? In what direction do they extend?

Is there any complaint of skin: such as discolouration, itching, eruptions, ulcers, warts etc. (Describe its nature)

Is there any complaint with the Nails?

Is there any complaint with the Hair such as falling, graying, poor or excessive growth etc.?

SLEEP: How is your sleep?

Your posture in sleep: lying on the back, side, abdomen etc.:

Are you able to sleep in any position?

Do you feel refreshed or worse after sleep?

Do you get dreams?

If frequent, mention nature of dreams and objects generally seen.

SWEAT: How much, on what parts and when?

Is it warm or cold?

Is it sour-smelling or bad smell?

Does it stain the clothes?

Do you get fever or chill frequently? If so, what brings it on?

When does it come on?

Have your weight or size increased or reduced recently or after onset of the illness?

If so, is it noted more in any particular part?

Are you troubles one-sided?

Or more on one side?

Do they proceed from one to the other side?

Or do they alternate or shift?

Do wounds heal slowly?

Do wounds tend to form pus?

Have you a tendency to bleed?

Is there any trembling? If so, when and under what circumstance?

STATE HOW YOU ARE AFFECTED BY OR HOW YOU REACT TO THE FOLLOWING: ARE YOU UPSET OR RELIEVED BY ANY OF THESE?

1. Warmth in general: warmth of bed, of room etc.:
2. Cold in general: cold air, winds etc.:
3. Weather: dry, wet, cold, cloudy etc.:
4. Thunderstorms:
5. Open air; Fanning:
6. Near the sea and on the mountains:
7. Movement and rest: Fast & Slow motion:
8. Position and Posture:
   Lying down on the back, sides, abdomen etc.:
   Sitting, standing, rising, stopping etc.:
   Looking up, Looking down etc.:
9. Touch, Pressure and Massage:
10. Light, Noise, Smell etc.:
11. Sleep, Nap etc., or Loss of sleep:
12. Eating and Drinking:
    Before, during and after:
    Fasting:
    Particulars of items of food & drink which affect you or make you sick: e.g. Cabbage, Cold drinks, Eggs, Fats, Fish, Fried foods, Fruits, Milk, Onions, Potatoes, Pulses, Sour foods, Sweets etc.
13. Emotion; Anxiety, Grief, Joy etc.:
14. Exertion: Mental and Physical; Reading, Speaking etc.
15. Company, crowds etc.:
16. Ascending and Descending the stairs, in a lift etc.:
17. Bathing & Washing: cold, warm etc.: (Do you like a bath?)
18. Exposure to Sun:
19. Sweating, Passing Urine, Stool etc.:
20. Passing gas up or down:
21. Clothing etc.: woolen, cotton, Tight clothing:
22. In what part of the 24 hours do you feel best or worst?
23. Traveling: in bus, train, plane etc.:
24. Do your troubles occur or become worse periodically:
    e.g. daily, on alternate days, weekly, fortnightly, monthly, yearly, during new moon, full moon etc.?
25. Do they occur suddenly slowly or disappear suddenly/slowly?
26. Weather and Seasons: Summer, Winter, Cloudy, Rainy etc.:
27. Jarring, Jerking etc.:
28. Music & Dancing:
29. Change of position:
30. How is your health if you are constipated or have diarrhoea?

HAVE YOU NOTICED ANY MARKED CHANGES IN YOUR MENTAL STATE? IF SO, DESCRIBE FULLY.

Have you became:

Anxious or afraid of anything such as animals, being alone, darkness, death, diseases, robbers, sudden noises, thunder, high places etc.?

Doubtful? Suspicious?

Impatient? Hurried? Slow?

Offended easily?

Irritable? Quarrelsome? Violent? Abusive, etc?

Depressed, Sad, Brooding etc.?

Diffident? Or Proud?

Disgusted of anything? Or Suicidal?

Jealous?

Changeable? Or Indecisive?

Shy? Timid? Cowardly?

Indifferent to anything such as business, relatives etc.?

Restless?

Nervous or Excitable? If so, what happens to you when you are nervous?

Silent or talkative?

Sexual-minded?

Are you very affectionate?

Do you weep or sigh easily; if so, what makes you weep? How do you feel after weeping?

How do you like and react to sympathy?

How do you like and react to contradiction?

Do you suppress your feelings?

Have you any imaginary feelings or fears?

Do you get started? If so, when?

How is your mental capacity and memory?

Do you make mistakes? If so, of what type?

Do you regret anything?

Are you seriously worried or unhappy over any personal, domestic, economical, social or any other problems? If so, describe the situation in detail:

PREVIOUS HISTORY:

State ALL major illnesses suffered so far (including accidents, food poisonings etc.) such as Malaria, Typhoid, Measles, Small pox, Pneumonia, Pleurisy, etc., with approximate dates and duration. Mention whether you completely recovered your health after each.

(Women should mention abortions, miscarriages etc., if any, and the condition of their health during pregnancy.)

Have you ever suffered from any serious shock, grief, disappointments, fright, mental upset, etc.?
If so, describe in detail:

Is their any abnormality, swelling, numbness, paralysis etc., in any part of the body?

Did you suffer from any skin disorder? If so, how was it cured?

Did you suffer from any venereal disease?

Have you been vaccinated? How often? With what results?

Are you used to alcohol, smoking, tea, coffee, tobacco, or any drug etc. (mention quantity)

Have you ever had any accident? Any injury to the body or head?

Did you ever become unconscious? If so, when and how long?

Are aluminum vessels used for preparing or storing your food?

Did you have any bad habits?

Were you bitten by any animal, or poisonous insects?

For Children:

At what age did teething, walking and talking start?

Were growth and development normal?

Did the mother have any illness during pregnancy?

Was the child born at full term? By normal delivery?

FAMILY HISTORY: State age and condition of health of the following: (If anyone is not alive, state age at and the cause of death)

Father: Mother:

Brothers & Sisters: Married or Single:

Partner (Wife or Husband): Year of Marriage:

Children living (if any children died, state causes):

Any abortions or still births:

Did any relative of yours suffer from anemia, cancer, diabetes, insanity, rheumatism or tuberculosis?

PREVIOUS TREATMENT: State all the medicines and treatments (including operations and their results) taken so far (as far as you know) and the results:

Nutritec Software Symptom Survey

NAME: _____ **DATE:** _____

Phone: _____ **E-mail:** _____

Fax: _____ **DOB:** ____/____/____

Sex : ☐ **Male** ☐ **Female** **Tissue Calcium:**_____

Height : _____ **Weight :** _____

Blood Pressure: **Pulse:**____

Sitting:_____ **Laying:**_____ **Standing:**_____

INSTRTIONS: Completely black out one of the three circles: 1-mild, 2-moderate, 3-severe

● ○ ○ **MILD** symptoms (once or twice last 6 months)
○ ● ○ **MODERATE** symptoms (once or twice last month)
○ ○ ● **SEVERE** symptoms (Chronic, once or twice last week)
○ ○ ○ Leave circles **BLANK** if they do not apply to you!

	1	2	3	
				---------- GROUP 1 ----------
1	○	○	○	Acid foods upset
2	○	○	○	Feel chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meals
6	○	○	○	Keyed up; unable to feel calm
7	○	○	○	Cuts heal slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold and/or clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Body temperature rises easily
18	○	○	○	Skin sensitive to touch
19	○	○	○	Staring, blinks little
20	○	○	○	Frequently has a sour stomach
				---------- GROUP 2 ----------
21	○	○	○	Joint stiffness after rising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen or puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; "lightheaded" often
29	○	○	○	Food digests rapidly
30	○	○	○	Vomit frequently
31	○	○	○	Frequently hoarse
32	○	○	○	Irregular breathing
33	○	○	○	Pulse slow or feels "irregular"
34	○	○	○	Slow gag reflex
35	○	○	○	Difficulty swallowing
36	○	○	○	Alternating constipation and diarrhea
37	○	○	○	"Slow starter"
38	○	○	○	Not easily chilled
39	○	○	○	Perspire easily
40	○	○	○	Poor circulation or sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				---------- GROUP 3 ----------
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetitie

	1	2	3	
				---------- GROUP 3 continued ----------
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Feeling fatigued, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Upset feeling from excessive eating of sweets
52	○	○	○	Awaken after few hours sleep hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				---------- GROUP 4 ----------
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	Discomfort at high altitude
60	○	○	○	Opens windows in closed room
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon yawner
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles worse at night
65	○	○	○	Muscle cramps, worse during exercise; "charley-horse"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily,"black/blue"spots on arms or legs
69	○	○	○	Tendency to anemia
70	○	○	○	Frequently have "nose bleeds"
71	○	○	○	"Ringing in ears" or noises in head
72	○	○	○	Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion
				---------- GROUP 5 ----------
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter or metallic taste in mouth in the mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Feelings of worry, dread, or insecurity
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upsets
85	○	○	○	Stools light-colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Using laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmares/bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				---------- GROUP 6 ----------
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucus colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

Optimum Health Centre
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	1	2	3	
				---------- GROUP 7A ----------
107	○	○	○	Insomnia
108	○	○	○	Nervousness
109	○	○	○	Can't gain weight
110	○	○	○	Intolerance to heat
111	○	○	○	Highly emotional
112	○	○	○	Flush easily
113	○	○	○	Night sweats
114	○	○	○	Skin is thin and moist
115	○	○	○	Inward trembling
116	○	○	○	Heart palpitates
117	○	○	○	Increased appetite without weight gain
118	○	○	○	Pulse races when resting
119	○	○	○	Eyelids and face twitch
120	○	○	○	Irritable and restless
121	○	○	○	Can't work under pressure
				---------- GROUP 7B ----------
122	○	○	○	Noticeable weight gain
123	○	○	○	Decrease in appetite
124	○	○	○	Easily fatigued
125	○	○	○	Ringing in ears
126	○	○	○	Sleepy during day
127	○	○	○	Sensitive to cold
128	○	○	○	Dry or scaly skin
129	○	○	○	Constipation
130	○	○	○	Mental sluggishness
131	○	○	○	Hair coarse, falls out
132	○	○	○	Headaches upon arising wear off during day
133	○	○	○	Pulse slow, below 65
134	○	○	○	Frequent urination
135	○	○	○	Impaired hearing
136	○	○	○	Reduced initiative
				---------- GROUP 7C ----------
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance
				---------- GROUP 7D ----------
142	○	○	○	Abnormal thirst
143	○	○	○	Bloating of the abdomen
144	○	○	○	Weight gain around hips or waist
145	○	○	○	Sex drive reduced or lacking
146	○	○	○	Tendency toward ulcers and/or colitis
147	○	○	○	Increased sugar tolerance
148	○	○	○	(FEMALE) Menstrual disorders
149	○	○	○	(YOUNG GIRLS) Lack of menstrual function
				---------- GROUP 7E ----------
150	○	○	○	Dizziness
151	○	○	○	Headaches
152	○	○	○	Hot flashes
153	○	○	○	Increased blood pressure
154	○	○	○	(FEMALE) Hair growth on face or body
155	○	○	○	Sugar in urine (not diabetes)
156	○	○	○	(FEMALE) Masculine tendencies
				---------- GROUP 7F ----------
157	○	○	○	Weakness and/or dizziness
158	○	○	○	Chronic fatigue
159	○	○	○	Low blood pressure
160	○	○	○	Nails weak and/or ridged
161	○	○	○	Tendency towards hives
162	○	○	○	Arthritic tendencies
163	○	○	○	Perspiration increase
164	○	○	○	Bowel disorders
165	○	○	○	Poor circulation
166	○	○	○	Swollen ankles
167	○	○	○	Crave salt
168	○	○	○	Brown spots or bronzing of skin
169	○	○	○	Allergies - tendency to asthma
170	○	○	○	Weakness after colds or influenza
171	○	○	○	Muscular and nervous exhaustion
172	○	○	○	Respiratory disorders

	1	2	3	
				---------- GROUP 8 ----------
173	○	○	○	Apprehension
174	○	○	○	Irritability
175	○	○	○	Morbid fears
176	○	○	○	Never seems to get well
177	○	○	○	Forgetfulness
178	○	○	○	Indigestion
179	○	○	○	Poor appetite
180	○	○	○	Craving for sweets
181	○	○	○	Muscular soreness
182	○	○	○	Depression; feelings of dread
183	○	○	○	Noise sensitivity
184	○	○	○	Acoustic hallucinations
185	○	○	○	Tendency to cry without reason
186	○	○	○	Hair is coarse and/or thinning
187	○	○	○	Weakness
188	○	○	○	Fatigue
189	○	○	○	Skin sensitive to touch
190	○	○	○	Tendency towards hives
191	○	○	○	Nervousness
192	○	○	○	Headache
193	○	○	○	Insomnia
194	○	○	○	Anxiety
195	○	○	○	Anorexia
196	○	○	○	Inability to concentrate; confusion
197	○	○	○	Frequent stuffy nose; sinus infections
198	○	○	○	Allergy to some foods
199	○	○	○	Loose joints
				---------- FEMALE ONLY ----------
200	○	○	○	Very easily fatigued
201	○	○	○	Premenstrual tension
202	○	○	○	Painful menses
203	○	○	○	Depressed feelings before menstruation
204	○	○	○	Excessive and prolonged menstruation
205	○	○	○	Painful breasts
206	○	○	○	Menstruate too frequently
207	○	○	○	Vaginal discharge
208	○	○	○	Hysterectomy / ovaries removed
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Long standing depression
				---------- MALE ONLY ----------
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Frequent night-time urination
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Too easily tired
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

List below your five main physical complaints in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Notes:

(TO BE FILLED IN BY A PHYSICIAN)

Physical Examination:

Appearance, Decubitus, Galt, etc:

Digestive System:

Respiratory System:

Circulatory System:

Urogenital: Locomotor:

Skin:

Weight: Height: Temp:

Pulse: B.P.: Resp:

Special Findings:

Laboratory Findings:
Blood:

Urine:

Stool:

Sputum:

X-Ray: ECG:

Diagnosis:

Treatment: