

Nature's Grace Wellness Center

PATIENT HEALTH HISTORY

NAME: _____
 (Last) (First)

DOB: ____ / ____ / ____ / SEX: M F

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE HAD (以下の病状につき、以前にあったものをチェックして下さい。)

NECK PAIN (首痛)	IMPOTENCE (インポテンツ)	ALLERGIES (アレルギー)	ASTHMA (喘息)
SHOULDER PAIN (肩痛)	OVERWEIGHT (肥満)	DIZZINESS (めまい)	RINGING EARS (耳鳴り)
CHEST PAIN (胸痛)	DRINKING OR DRUGS (アルコールまたは麻薬中毒)	ANXIETY/ NERVOUSNESS (不安) / (緊張)	DIARRHEA (下痢)
HAND/WRIST PAIN (手/腕痛)	CANCER OR TUMOR (癌または腫瘍)	PARALYSIS (麻痺)	CONSTIPATION (便秘)
BACKACHES (腰痛)	BLEED OR BRUISE EASILY (出血またはアザになりやすい)	DIABETES (糖尿病)	KIDNEY DISEASE (腎臓病)
KNEE PAIN (膝痛)	HIGH BLOOD PRESSURE (高血圧)	HEART TROUBLE (心臓病)	HEPATITIS (肝炎)
LEG PAIN/ FOOT/ANKLE PAIN (脚痛) / (足/足首痛)	ABDOMINAL PAIN OR CRAMPS (腹痛またはけいれん)	MUSCLE CRAMPS (筋肉けいれん)	

CURRENT PROBLEM:

ANY OTHER THAN ABOVE, PLEASE DESCRIBE (上記以外の病状がありましたら、ご記入下さい) :
