# Health History Form

Wodonga Chinese Medicine Clinic

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| Personal information |
| Name | Date | File number: |
| Address | Suburb/Town & State | Post code |
| Phone (H) | (W) | (M) |
| Email address |
| Date of birth | Sex | Country of birth |
| Occupation | Referred by |
| Health fund | GP |
| Sport or recreational activities |
| Main concern |
| Insurance claim  |

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| Medical History |
|  | Hypertension |  | Fainting or dizzy spells |
|  | Arthritis |  | Headache / migraines |
|  | High cholesterol |  | Varicose veims |
|  | Asthma |  | Blood Clots |
|  | Heart problems |  | Osteoporosis |
|  | Diabetes |  | Cancer |
|  | Epilepsy |  | Low back pain |
|  | Others  |

\*All information is held in the strictest confidence. Thank you for your cooperation.