

YEH CENTER OF NATURAL MEDICINE, INC.

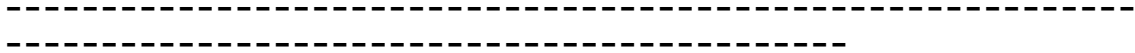
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**PERSONALIZED MEDICAL CONSULTATION - FORM A**

(Please Print)



**PERSONAL INFORMATION:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Age: \_\_\_\_ Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_

Who may we thank for referring this Food Medicine book to you? \_\_\_\_\_

What is your goal and objective for health, with help from this book? \_\_\_\_\_

Which statement best describes your outlook?

- If the information benefits my health, I am willing to make changes right away.
- If the information benefits my health, I will make slow and gradual changes.
- I just want to be informed about nutrition and diet.
- I am not willing to make dietary changes or give up my favorite foods.

**MEDICAL HISTORY:**

Primary Illness: \_\_\_\_\_ Duration of Illness: \_\_\_\_\_

Secondary Illness: \_\_\_\_\_ Duration of Illness: \_\_\_\_\_

Medical History: \_\_\_\_\_

Surgeries:	Procedure (Please be Specific):	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICATIONS AND SUPPLEMENTS:**

Drug Medications:

Drug Name:	Dosage:	Frequency Per Day:	Starting Day:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Natural Nutritional and Herbal Supplements:

Supplement:	Dosage:	Frequency Per Day:	Starting Day:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**BIOLOGICAL EVALUATION:**

1. Do you have high blood pressure?  yes  no      high cholesterol?  yes  no  
If yes, please explain: \_\_\_\_\_
2. Do you suffer from headaches, migraines or head pain?  yes  no  
If yes, please explain: \_\_\_\_\_
3. Do you suffer from dizziness or vertigo? Do you faint?  yes  no  
If yes, please explain: \_\_\_\_\_
4. Do you suffer from chest pains or shortness of breath?  yes  no  
If yes, please explain: \_\_\_\_\_
5. Date of EKG or stress test for the heart? \_\_\_\_\_  
What were the findings? \_\_\_\_\_
6. Do you suffer from pain of the hypochondriac region or rib cage?  yes  no  
If yes, please explain: \_\_\_\_\_
7. Do you suffer from upper or lower abdominal pain?  yes  no  
If yes, please explain: \_\_\_\_\_
8. Do you experience loss of appetite, nausea or vomiting?  yes  no  
If yes, please explain: \_\_\_\_\_
9. Do you suffer from anorexia, bulimia or compulsive eating?  yes  no  
If yes, please explain: \_\_\_\_\_
10. Do you have bodily aches and pains?  yes  no  
If yes, please explain: \_\_\_\_\_
11. How many times per year do you catch a cold or flu? \_\_\_\_\_  
How many days does it usually last? \_\_\_\_\_
12. Do you suffer from respiratory infections?  yes  no  
If yes, please explain: \_\_\_\_\_
13. Do you suffer from any of the following? Please circle all that apply:
- |               |                 |           |           |
|---------------|-----------------|-----------|-----------|
| chronic cough | runny nose      | sneezing  | asthma    |
| phlegm        | post nasal drip | rhinitis  | hay fever |
| bronchitis    | pneumonia       | sinusitis | allergies |

The color of my phlegm/mucous is usually:  
(Please circle all that apply.)

- Clear
- Yellow
- Orange
- Green
- Brown
- With Blood

Comments: \_\_\_\_\_

14. Do you suffer from food allergies?  yes  no  
If yes, please list foods that you are allergic to: \_\_\_\_\_

15. Do you have normal bowel movements, 2-3 times daily?  yes  no  
If no, please explain: \_\_\_\_\_

16. Do you suffer from diarrhea, dysentery or constipation?  yes  no  
If yes, please explain: \_\_\_\_\_

17. Is your urine color light yellow or dark yellow? \_\_\_\_\_

18. Do you have blood in the urine and painful or burning urination?  yes  no  
If yes, please explain: \_\_\_\_\_

19. How many glasses of water do you consume daily? \_\_\_\_\_ How many ounces? \_\_\_\_\_

20. Please explain your exercise routine:

21. Please explain how you relax and cope with stress:

22. How many hours do you sleep each night? \_\_\_\_\_  
 I sleep from \_\_\_\_ a.m. / p.m. to \_\_\_\_ a.m. / p.m.  
 I nap from \_\_\_\_ a.m. / p.m. to \_\_\_\_ a.m. / p.m.  
 Is your sleep disturbed? Please explain: \_\_\_\_\_
23. Do your hands and feet feel cold, numb or tingly?  yes  no  
 If yes, please explain: \_\_\_\_\_
24. Do you suffer from uncontrolled movement(s) or seizures?  yes  no  
 If yes, please explain: \_\_\_\_\_
25. Do you suffer from mood swings, anxiety, anger or depression?  yes  no  
 If yes, please explain: \_\_\_\_\_
26. Have you been diagnosed with cancer, tumors or cysts?  yes  no  
 If yes, please explain: \_\_\_\_\_
27. Do you smoke cigarettes, drink alcohol or take drugs?  yes  no  
 If yes, please explain: \_\_\_\_\_
28. Do you have hair loss or gray hair?  yes  no  
 If yes, please explain: \_\_\_\_\_
29. Do you have wrinkles, dry skin, skin flaws and/or blemishes?  yes  no  
 If yes, please explain: \_\_\_\_\_
30. Do you suffer from hypoglycemia or hyperglycemia?  yes  no  
 If yes, please explain: \_\_\_\_\_
31. Do you suffer from hypothyroidism or hyperthyroidism?  yes  no  
 If yes, please explain: \_\_\_\_\_
32. Do you have tendinitis, bursitis, arthritis or osteoarthritis?  yes  no  
 If yes, please explain: \_\_\_\_\_
33. I have a tendency to feel (cool, cold, warm, hot)? (please circle one)  
 I enjoy (spring, summer, autumn, winter) the most? (please circle one)
34. Please circle all that apply to your personality:  
 Aggressive    Loud    Talkative    Fun-Loving  
 Friendly    Social    Organized    Picky/Choosy  
 Quiet    Shy    Passive    Generous
35. Please circle all that apply to your lifestyle:  
 Prefer Outdoor    Athletic    Active    Prefer Indoor    Sedentary

36. Please circle the emotion that most applies to you:

Anger                  Sadness                  Fear                  Joy                  Worry

37. How many hours a day do you engage in ... (24 hours total)?

studying? \_\_\_\_\_ working? \_\_\_\_\_ sleeping/napping? \_\_\_\_\_  
playing? \_\_\_\_\_ exercising? \_\_\_\_\_ resting/relaxing? \_\_\_\_\_

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**WOMEN ONLY:**

Do you have reoccurring yeast, bladder or urinary tract infections?  yes  no

If yes, please explain: \_\_\_\_\_

Have you ever been pregnant?  yes  no

If yes, please explain any difficult pregnancies or complications during childbirth:

Number of total pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

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**MENSTRATING WOMEN ONLY:**

Are you currently pregnant?  yes  no

If yes, how many months: \_\_\_\_\_

Do you suffer from abnormal menstrual cycles?  yes  no

If yes, please explain: \_\_\_\_\_

During menstruation, do you have cramps?  yes  no

If yes, please explain: \_\_\_\_\_

Do you suffer from PMS?  yes  no

If yes, please explain: \_\_\_\_\_

Are you on birth control pills?  yes  no

If yes, for how long? \_\_\_\_\_ Please explain: \_\_\_\_\_

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**MENOPAUSE WOMEN ONLY:**

Are you undergoing hormone replacement therapy?  yes  no

If yes, please explain: \_\_\_\_\_

How long have you experienced absence of menstruation? \_\_\_\_\_

Do you suffer from menopause symptoms?  yes  no

If yes, please explain: \_\_\_\_\_

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**HYSTERECTOMY PATIENTS ONLY:**

What were the reasons for the hysterectomy? \_\_\_\_\_

Was it a partial or complete hysterectomy? \_\_\_\_\_

When did you have the hysterectomy? \_\_\_\_\_

Are you undergoing hormone replacement therapy?  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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**MEN ONLY**

Do you have prostatitis or prostate enlargement?  yes  no

If yes, please explain: \_\_\_\_\_

Have you had a vasectomy?  yes  no

If yes, please explain: \_\_\_\_\_

Do you suffer from impotence or sterility?  yes  no

If yes, please explain: \_\_\_\_\_

Do you have nocturnal emissions?  yes  no

If yes, please explain: \_\_\_\_\_

Do you have painful ejaculation or premature ejaculation?  yes  no

If yes, please explain: \_\_\_\_\_

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I Would Like More Information On: \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**After completing this form, please make a copy and return  
it to the receptionist office. Thank you.**

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The information I have provided is true and accurate to the best of my knowledge. I understand that this information will be held in strict confidentiality between the medical staff at Yeh Center of Natural Medicine, Inc. and myself.

The purpose of “Medical Consultation” is to familiarize the patient with herbal medicine, nutrition, and diet on an individualized basis. The manual does not make any health claims, and the information introduced does not take the place of physician’s care, medical procedures, lab tests, or any necessary medication.

Yeh Center of Natural Medicine, Inc. also does not in any way encourage any person to try to heal themselves or to stop their current medical care and supervision, as all medical treatment requires the knowledge and skill of a trained professional. Due to the personalized nature of this medical consultation program, long hours are spent putting it together. Therefore, there is no exchange or refund . I have read and understand the above statements.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_