**COMLETE PATIENT FTD**

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| **Name** |  | **Date** |  |

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| **MAIN COMPLAINT** | | | **Secondary/Other Complaints** |
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| **Duration (when did it start, what was happening)** | | | **Location** |
| **Quality (heavy, throbbing, griping, sharp, numb, boring)** | | | **Intensity (dull/strong 1-10)** |
| **Continuous/Intermittent (regularly so, frequent, pattern)** | | | **Worse/better (time, season, temperature, climate, movement)** |
| **Can/can’t do** | | | **Accompanying symptoms** |
| **Other treatments** | | | |
| **SYSTEMS** | | | |
| **Sleep (quality, quantity, insomnia, drugs, dreams)** | | **Food & Taste (appetite, digestion, likes/dislikes, taste, diet, allergies/sensitivities)** | |
| **Thirst & Drink (quantity, thirst, type, alcohol)** | |
| **Urine (quantity, colour, odour, pain, enuresis)** | | **Bowels (when, consistency, diarrhoea/constipation, blood/mucus, pain)** | |
| **Sweating/temperature (how much/when, hot or cold where/when)** | | **Energy levels** | |
| **WOMAN** | **Menstruation (regularity, length of period, blood, pain, emotions, age when started)** | **Pregnancy/childbirth (how many, miscarriages, infertility, type of birth, post-birth, still birth)** | |
| **Discharges (colour, smell, amount)** | **Menopause (what age, symptoms emotional/physical)** | |
| **Contraception (pill, coil, other)** | **Day of cycle / Other** | |

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| **Headaches (onset, time, location, type of pain, better/worse)** | **Dizziness (onset, acute/chronic, postural, slight/strong, better/worse)** |
| **Eyes (normal, short/long sighted, blurred vision, floaters, dry pain, irritations, red/bloodshot)** | **Ears (quality of hearing, tinnitus – onset, pressure, character of noise)** |
| **Numbness (where, onset, time, duration)** | **Thorax and Abdomen (chest, flanks, epigastrium, hypochondrium, abdomen – pain or distension)** |
| **Pain (where, onset, full/empty, fixed/moving, better/worse – hot and cold or activity)** | **Climate (better/worse in hot/cold/damp/wind/dry etc)** |
| **Moods** | **Immune system (prone to infections, easily catch colds)** |
| **Skin, hair, nails** | **Smoking** |
| **Other (skin, allergies?)** | |

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| **MEDICAL AND PERSONAL HISTORY** |
| **Birth and early childhood (premature, difficulties, caesarean, planned/wanted, breast fed, vaccinations)** |
| **Chronology of illnesses + accidents, injuries, operations** |
| **Medication** |