Medical History

Date:

Patient's Name: _____

Contact Number: _____

Email Address: _____

DOB: _____ Single: _____ Married: ____ Divorced: _____ Widowed: _____

Have you had any exam or any medicine to take? Yes ( ), No ( )

If so, why and when? _____

Hyper tension ( ) Diabetes ( ) Cholesterol ( ) Others ( )

Do you take psychological or neuropsychiatric history? Yes ( ) No ( )

If so, why and When _____

Where do you mainly have problem with? Explain: _____

_____

Are you pregnant? Yes ( ) No ( ) Last menses period? _____

Do you have any problem with (Check)? Kidney ( ) Liver (Hepatitis) ( ) Seizures ( )

Do you have any history of surgical treatments in the past? Yes ( ) No ( ) If yes, explain _____

Do you have infectious disease history? Yes ( ) No ( ) If yes, explain: _____

HIV test? Yes ( ) No ( ) If yes, explain _____

Do you smoke, drink or drugs? Yes ( ) No ( ) If yes, explain (Drink): _____ times / a week

If yes, explain (Smoke) _____ times / a week

I agree that Miraclehandsinyu has no responsibility on any medical history has not been noted on this list.

Patient's Signature: _____ **Healer signature:** _____