



MEDICAL HISTORY - confidential

GENERAL INFORMATION

Name _____

Age _____ DOB ____/____/____ Gender Male Female Email Address _____

Telephone (work) _____ (home) _____

Occupation _____

Mailing Address _____

Primary Practitioner (Medical Doctor) _____ Date of last visit ____/____/____

Telephone _____

Reason for Visit _____

Have you received Acupuncture/Chinese Herbs in the past? Yes No

Name of Acupuncturist _____ Date of last visit ____/____/____

Reason for Visit _____

EMERGENCY CONTACT

Name _____ Relationship _____

Telephone _____

MAJOR CONCERN

What is your primary reason for this visit? _____

This condition is due to Automobile Injury Work Injury Sports Injury Illness Not Sure Other

If Other, please explain _____

What was the date of the illness or injury? ____/____/____ When did your symptoms begin? ____/____/____

How did your symptoms develop? Gradually or Suddenly How long do symptoms last? _____

What initiates your symptoms? _____

What makes them worse? _____

What makes them better? _____

Have you received treatment for this concern? Yes No

If yes, what was done and did it help? _____

Is there a pattern to when your symptoms occur? Yes No

If yes, what is the pattern?

In the morning

Occasionally

During sleep

In the evening

Intermittently

Upon waking

All day

Constantly

Other _____

Do you have specific questions you would like to discuss today? _____

CURRENT MEDICATIONS

Please check all that apply:

Prescribed medications/over-the-counter medications

Recreational drugs

Vitamins/supplements/herbs

Homeopathic remedies

Please list all current medications, supplements, etc.

<i>Current Medication</i>	<i>Reason</i>	<i>Date began</i>	<i>Dose</i>	<i>Helps? Yes or No</i>
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to:

Please check and describe any problems or change in function in the following areas:

Headaches

Weight

Vision (dry eyes, blurry vision, floaters, infection)

Nose/Sinuses (allergies, sinus infections)

Respiratory Problems (asthma, cough, excessive phlegm, shortness of breath)

Throat (recent or recurrent infections)

Digestion (bowel problems, diarrhea, bloating, gas, changes in appetite, GB inflammation/stones)

Stomach (ulcers, acid reflux, heartburn)

Energy and Immunity (fatigue, chronic infections, Chronic Fatigue Syndrome)

Endocrine/Body Temperature (hypo/hyperthyroid, night sweats, feeling hot or cold)

- Mouth/Teeth/Gums (dental procedures, cold sores/Herpes, TMJ/grinding)
- Skin (eczema, rashes, acne, edema [swelling])
- Heart Disease (shortness of breath, palpitations, chest pain, high/low blood pressure)
- Urination (frequency, pain, dribbling, impaired urination, history of UTIs)
- Kidney (kidney disease, kidney stones)
- Sexual Function/Libido
- Neurological Symptoms (vertigo/dizziness, paralysis, numbness/tingling)
- Problems Sleeping
- Emotions (mood swings, nervousness, mental tension, past or recent trauma)
- Musculoskeletal Problems (circle all that apply)

Muscle Spasms/Cramps

Back: Sacrum/Low/Middle/Upper

Elbow

Hand/Wrist

Foot/Ankle

Knee

Neck

Shoulder

FAMILY HISTORY

Check illnesses which have occurred in any of your blood relatives.

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |

PERSONAL HISTORY

Check any past or present illnesses or conditions.

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Antibiotic use | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | |

Do you have any infectious diseases? Yes No

If yes, please identify: _____

WOMEN

Age at time of first menstrual period _____ Date of last Ob/Gyn exam ____/____/____

Type of birth control _____

Do you have any reason to believe you may be pregnant? Yes No

If so, how far along are you? _____

Menopause Age at onset _____ Hot flashes Yes No Night sweats Yes No

Menstrual flow Light Medium Heavy Varies

Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> PMS | <input type="checkbox"/> Cervical dysplasia |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Abnormal PAP smear |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Infertility issues | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Ovarian cysts/PCOS (polycystic ovarian syndrome) | |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Uterine fibroids | |

MEN

Date of last prostate exam ____/____/____

Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Prostate problems (Benign Prostatic Hypertrophy, prostatitis, etc.) | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Testicular problems |

Please list illnesses requiring surgery [include dates] _____

Please list any other serious injury (broken bones, scars, etc.) _____

Thank you for your time and for filling out this form as completely as possible.

Please remember all information given is strictly confidential.

I have read and filled out the above information to the best of my knowledge. ***I am responsible for making my practitioner aware of any changes in my conditions on an on-going basis before any therapy is administered.***

SIGNATURE OF PATIENT

DATE