Medical History

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask any of our staff members.

If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Additional Comments" section.

Thank you!

Date:

CONTACT INFORMATION:

Full Name:

Cell phone: **Home phone:** **Work phone:**

Email address:

Address: **City:** **Zip Code:**

PERSONAL INFORMATION:

Date of Birth:

Gender (please circle): **Male** **Female**

Age: **Height:** **Current weight:**

Occupation: **Employer:**

Primary care physician (Doctor's and practice name):

Emergency Contact (First & Last name): **Relation to you:**

Emergency Contact phone number:

MEDICAL INFORMATION:

Have you been treated with acupuncture or Oriental medicine before? **Yes** **No**

Purpose of your visit or main health concern(s) you would like us to help you with:

How long ago did this issue begin? Please be specific.

Have you been given a diagnosis for this health issue? **Yes** **No**

If yes, please be specific:

What other type of treatment have you tried to address this concern?

FAMILY MEDICAL HISTORY

Please circle all applicable:

Asthma Allergies Diabetes Cancer Heart Disease High Blood Pressure Stroke Seizures Thyroid Conditions Psychiatric Conditions

Other (please specify):

MEDICAL HISTORY & LIFESTYLE (please include dates if possible)

Please circle all conditions that may apply to you:

Cancer Diabetes Hepatitis High Blood Pressure Heart Condition Rheumatic Fever Thyroid condition Seizures Venereal Disease Autoimmune Condition Asthma Psychiatric Conditions

Infectious disease (please specify):

Other (please specify):

Please list any surgeries you previously had:

Please list any significant trauma (auto accidents, falls, etc.) you had:

Please list with detail any allergies you have:

Please list all medicines that you are currently taking or have taken within the past two months:

Medical History

Please list all vitamins, supplements and/or herbs that you are currently taking or have taken within the past two months:

How would you describe your stress level? Low Medium High
If applicable, what would you say is the main source of stress in your life (family, work, financial, etc.)?

Do you have a regular exercise program? Yes No
If yes, please describe:

Are you or have you been on a restricted diet? Yes No
If yes, please describe:

Do you smoke? Yes No If yes, how much?

Do you drink alcohol? Yes No If yes, how much?

Do you take any drugs for any purpose different than medical treatment? Yes No

Please circle if you have experienced any of these symptoms and/or conditions in the past six months:

1. **General:**

Fever Peculiar tastes or smells Strong thirst (hot or cold drinks) Sweat easily Cravings Poor sleep Night sweats Change in appetite Fatigue Chills Weight loss Weight gain Bleed or bruise easily Mood changes Dizziness Headaches Fainting Anemia

2. **Skin & Hair:**

Rashes Ulcerations Hives Itching Eczema Acne Dandruff Hair loss Growing moles Change in hair or skin texture Dry hair or skin Oily hair or skin
Any other hair or skin related issues?

3. **Head, eyes, ears, nose, and throat:**

Poor vision Eye pain Night blindness Color blindness Blurred vision Dry eyes Itchy eyes Eye redness Ear aches Itchy ears Ringing in the ears Poor hearing Sinus problems Nose bleeding Recurrent sore throats Difficulty swallowing Grinding teeth

Facial pain/numbness **Teeth problems** **Sores on lips, gums, or tongue**
Any other related issues?

4. **Cardiovascular:**

Chest pain **Blood clots** **Irregular heartbeat** **Cold hands or feet** **Phlebitis**
High blood pressure **Low blood pressure** **Swelling of the feet or legs** **Peripheral Arterial Sclerosis**
Swelling of the hands **Varicose veins** **Palpitations** **Chest heaviness/oppression**
Any other heart or blood vessel problems?

5. **Respiratory**:

Cough **Asthma** **Shortness of breath** **Coughing blood** **Tight chest**
Difficulty breathing **Deep breathing discomfort** **Bronchitis** **Wheezing** **Pneumonia**
Difficult breathing when lying down **Phlegm congestion**
Any other respiratory issues?

6. **Gastrointestinal**:

Nausea **Diarrhea** **Abdominal pain or cramps** **Vomiting** **Constipation**
Abdominal noises **Rectal pain or discomfort** **Indigestion** **Blood in stools** **Mucus in stools**
Hemorrhoids **Gas** **Black stools** **Bad breath** **Heart burn** **Acid Reflux** **Belching**
Bleeding gums **Loose stools**
Any other problems with your stomach or intestines?

7. **Urinary**

Frequent urination **Pain upon urination** **Kidney stones** **Urgency to urinate** **Blood in urine**
Smelly urine **Dark urine** **Cloudy urine** **Profuse urination** **Urine retention** **Protein in urine**
Do you wake up at night to urinate? **Yes** **No** **If yes, how many times?**
Any other problems with your or urinary system?

8. **Male Reproductive:**

Impotence **Premature Ejaculation** **Testicular pain/injury** **Prostatitis** **Spermatorrhea**
Testicular Cancer **Prostate Cancer** **Low/Poor sperm count/quality** **Sores on genitals** **STD**
Benign Prostatic Hypertrophy **Low sexual drive** **Excessive sexual drive** **Painful/difficult coitus**

Any other reproductive issues?

9. Female Reproductive:

Are you pregnant? Yes No

Is it possible that you are pregnant and you don't know it yet? Yes No

Are you on any type of birth control? Yes No

At what age did you get your first period?

Number of pregnancies:

Any miscarriages/abortion: Yes No If yes, how many?

Any premature births? Yes No

Menopause age:

Last PAP/Gyn check up:

Please circle if you have experienced any of these symptoms and/or conditions in the past six months:

Abnormal vaginal discharge (dark, sticky, smelly) Irregular periods Heavy Periods Painful periods Sores on genitals Infertility STD Western Fertility Treatment PMS Scanty periods Low sexual drive Excessive sexual drive Painful/difficult coitus Hormonal imbalances

Any other reproductive issues?

10. Musculoskeletal:

Neck pain Hand/wrist pains Foot/ankle pains Shoulder pain Hip pain Back pain Knee pain Muscle weakness/atrophy General muscular pain Fractures Bone density issues Osteoporosis Bone deformity Limited motion Low back pain Arthritis

Any other muscle, joint or bone issues?

11. Neurological:

Seizures Dizziness Numbness Stroke Loss of Balance Poor memory Concussion Lack of coordination Tremors

Any other neurological problems?

12. Psychological:

Depression Irritability Tendency to sadness Anxiety Easily susceptible to stress Panic attacks PSTD Mania Insomnia Excessive sleeping

Have you ever been treated for emotional/ Psychiatric conditions? Yes No

If yes, please describe the condition treated:

Have you ever considered or attempted suicide? Yes No

Any other neurological or psychological issues?

ADDITIONAL COMMENTS: Please briefly describe any other issues or concerns you would like to discuss with us

Printed Name: _____

Signature: _____

Date: _____

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