

Medical History Form

Today's Date: _____

Name: _____ SS#: _____ Birthdate: ___/___/___
Address: _____ City: _____ State: ___ Zip: ___
Home Phone: _____ Work Phone: _____ Occupation: _____

Marital Status: _____ M F Ht: _____ Wt: _____ Age: _____

Emergency Contact Name & Phone#: _____

Treating Physician: _____ Physician Phone#: _____

Referred By: _____

Have you ever had acupuncture before? Y N Chinese Herbal Medicine? Y N

Reason for your visit today? _____ Initial cause? _____

How long have you had this condition? _____

What makes it better? _____ What makes it worse? _____

Other concurrent therapies? _____

Family Medical History

- | | | | | |
|------------------------------------|---|--|--|-------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| _____ | <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| _____ | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Goiter | <input type="checkbox"/> Alcoholism |

Your Medical History

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Surgery (list) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | _____ | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | _____ | |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Whooping |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Major Trauma | <input type="checkbox"/> Other |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | (car, fall, etc.-list) | _____ |
| (Your own birth) | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | _____ | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | _____ | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | _____ | _____ |

Your Diet

Appetite

- | | | | | |
|-------------------------------|--------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Low | <input type="checkbox"/> Coffee | <input type="checkbox"/> Artificial | <input type="checkbox"/> Sugar | <input type="checkbox"/> thirsts for |
| <input type="checkbox"/> High | <input type="checkbox"/> Soft Drinks | sweetener | <input type="checkbox"/> Salty food | water per day |

Average Daily Menu

Morning	Snack	Noon	Snack	Evening
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Pharmaceuticals taken in last 2 months: _____

Vitamins/supplements taken in last 2 months: _____

Your Lifestyle

- | | | | |
|----------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | <input type="checkbox"/> Regular Exercise |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational Health | Type: _____ |

General Symptoms

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Peculiar taste |
| <input type="checkbox"/> Like cold drink | <input type="checkbox"/> Fever | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Like hot drinks |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Vertigo/dizziness | <input type="checkbox"/> Lack of strength |
| <input type="checkbox"/> Recent weight loss/gain | | <input type="checkbox"/> Dream disturbed sleep | | |

Head, Eyes, Ears, Nose, Throat

- | | | | | |
|--------------------------------------|---|---|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Lump in throat |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Concussions | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Earaches | <input type="checkbox"/> TMJ | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Lumps in throat |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Blurred vision | | |

Respiratory

- | | | | | |
|---|---|--------------------------------|--|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> Cough | <input type="checkbox"/> Color of Phlegm _____ | <input type="checkbox"/> Coughing blood |
| | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> wet | | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Shortness of breath | | <input type="checkbox"/> dry | | |

Cardiovascular

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

Gastrointestinal

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bowel movements: frequency _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Burning anus | color _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Gas | texture/form _____ |
| <input type="checkbox"/> Black stool | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Rectal pain | |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Bad breath |

Musculoskeletal

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> limited use _____ |

Skin and Hair

- | | | | | |
|--|--------------------------------------|------------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hair loss | | |

Neuropsychological

- | | | | |
|-----------------------------------|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Attempt/consider suicide |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing a therapist | <input type="checkbox"/> Other _____ |

Genital-urinary

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Pain urinating | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Increased libido |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Premature ejaculation | | <input type="checkbox"/> Impotence |

Gynecology

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Age menstrual cycle began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal discharge color _____ | <input type="checkbox"/> Breast lumps # pregnancies _____ | <input type="checkbox"/> Date of last PAP _____ |
| <input type="checkbox"/> length of cycle _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> # live births _____ | <input type="checkbox"/> Date of last period _____ |
| | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Premature _____ | |
| | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | <input type="checkbox"/> Age at menopause _____ | |

Other: _____
