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MEDICAL HISTORY

Date:_____

Name:_____Referred by:_____Age: _____

Address_____City_____State_____Zip_____

Email: _____

Phone (home)_____(cell)_____(work)_____

Date of Birth: _____Time of Birth: _____Place of Birth:_____

Height:_____ Weight: _____ Marital Status: _____

Occupation: _____ Special Stress:_____

With whom do you live? _____

Why are you coming in for acupuncture? (What is your chief complaint)?

_____

Details (hot/cold; pain/ache; moving/localized; sharp/dull; etc.)

_____

_____

History_____

Other Complaints _____

_____

Name/Address of Primary Care Physician: _____

_____

Names of other health care providers (Acupuncturist, Chiropractors, Therapists, etc.)

_____

_____

_____

Surgeries: _____

_____

Other Hospitalizations: _____

Injuries/Accidents: _____

_____

Other Diseases: _____

_____

Medications (taken in the last month, prescription and non- prescription drugs with date and dosage if possible) _____

_____

_____

Known Allergies: _____

_____

SYMPTOMS REVIEW

Directions: Circle or underline any of the following problems that have bothered you in the last 6 months. Comment in the space provided regarding symptoms frequency (e.g. daily, weekly), time of last occurrence, duration opportunity to discuss all problems with the doctor.

SYMPTOMS **COMMENTS**

Head: Headaches Dizziness

Eyes: Vision problems Double Vision
Blurred Vision

Ears: Poor Hearing Earaches Discharge
Ringing in ears

Nose: Poor sense of smell Colds
Obstructions

Mouth: Pain Ulcers in mouth Bleeding gums
Unusual dental problems Sore Tongue

Respiratory: Cough Thick Sputum Wheezing
Bloody Sputum Night Sweats
Pain with Breathing Shortness of Breath
Abnormal Chest X-ray

Heart: Chest Pain or Pressure Ankle Swelling
Heart Palpitations Exercise intolerance

Blood: Previous history of Anemia
Tendency to bruise or bleed
Easily swollen lymph glands

Gastrointestinal:
Poor appetite Heartburn Pain with Eating
Increased gas Nausea Vomiting
Diarrhea Constipation Abnormal Color Stool
Hernia Hemorrhoids Jaundice/Yellow Skin Color

SYMPTOMS **COMMENTS**

Urinary: Burning or pain with urination
Change in quantity of urine
Constant Thirst
Urgency to urinate more frequently
Need to urinate more at night
Hesitancy Dribbling
Passing of stones
Loss of force to stream
Abnormal color
Urination with cough/sneeze

Reproduction: History of venereal diseases

Men: Impotence Premature Ejaculation

Women: Lack of periods Increase of blood flow
Abnormal bleeding Pain with periods
Vaginal discharge Vaginal pain
Vaginal itching Bumps/sores in vagina
Frigidity

Endocrine: Neck enlargement Hair/Nail changes
Intolerance to heat or cold
Breast lumps
Discharge from breast/nipples
Adrenal Pituitary Thyroid Pancreas
Hepatitis Hot Flashes

Skin: Rash Itching Dryness
Oily Pigment changes Acne
Abnormal sweating Hives
Changing moles or lumps

Neurological: Nervousness Insomnia Drowsiness
Abnormal Tremors/Shaking Incoordination
Convulsions Paralysis Memory Changes
Numbness/Tingling of hands/feet
Nerve Pain/ Neuralgia Herpes

SYMPTOMS **COMMENTS**

Musculoskeletal:

Arthritis Swelling of Joints
Deformity Muscular Cramps
History of Joint Diseases Accident
Muscle Weakness Back Pain Joint Pain

General Health:

Abnormal weight loss Abnormal weight gain
Fatigue Loss of feeling of wellbeing
Unexplained fever or chills
Lack of energy or excess of energy

List below the problems that concern you the most in order of importance

Menstruation (regularity/no. of days/heavy/light/pain/depression/changes caused/menopause)

_____

_____

_____

Last period began _____ Pregnancies (easy/hard)_____

Pill: Never_____ How Long: _____

Smoking: _____

Nutrition
How much of the following do you drink?

Coffee_____ Black Tea _____ Alcohol _____ Soda _____

Circle foods that you normally eat:

Hamburger Beef Lamb Pork Hot Dogs Ham
Eggs Whole Milk Chicken Fish Turkey Fruits Bacon
Fresh Vegetables Avocados Nuts Cheese Cake
Cookies Candy Chocolate Salt Butter Margarine Kefir
Ice Cream Yogurt Brown Rice Millet Tofu Beans Grains
Fried Foods Protein Drinks Sugar Other:

Have you been on a diet recently? _____ If yes, what type?_____

List vitamins and mineral supplements presently being taken

_____

List below a typical days meal:
Breakfast Lunch Dinner Snacks

List your favorite tastes:

_____

Exercise (circle the following sports that you do)

Walking Jogging Heavy Gardening Yoga Pilates

Swimming Stretch Exercises Other (specify) _____

Social:
What type of work do you do or have you done?

_____

Are you aware of any work related health hazards?

_____

What type of hobbies do you have?

Do you have any strong religious or philosophical feelings about your healthcare?

Personal (Strictly confidential)

What type of person are you?

What do you think about yourself?

How do you feel about your body?

How do you feel about your emotions?

What is your favorite?

Color _____Climate_____ Season _____ Time of year_____

How do you handle stress?

What is your general energy level? (physically, mentally, psychically, socially)

Any events in your life that have troubled you excessively in the past year?

Do you have any financial problems?

Do you enjoy your work?

How would you describe yourself emotionally – friendships, family, marriage, and depression?

Are you sexually active? Is it a problem for you?

What is your reaction to illness?

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Do you have any special fears or anxieties that bother you?

How do you feel that your life is going?

Do you want to change anything about yourself?