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

☐*Allergies*	☐*Arteriosclerosis*	☐ *Cancer*	☐*Diabetes*	☐*Seizures*
_____	☐*Asthma*	_____	☐*Heart Disease*	☐*Stroke*
_____	☐*Arthritis*	☐*High Blood Pressure*	☐*Goiter*	☐*Alcoholism*

Your Medical History

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

Your Diet

Appetite

☐*Low*	☐*Coffee*	☐*Artificial*	☐*Sugar*	☐*thirsts for*
☐*High*	☐*Soft Drinks*	*sweetener*	☐*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

☐*Alcohol*	☐*Marijuana*	☐*Stress*	☐*Regular Exercise*
☐*Tobacco*	☐*Drugs*	☐*Occupational Health*	*Type:*_____

General Symptoms

☐ *Poor appetite*	☐ *Poor sleep*	☐ *Bodily heaviness*	☐ *Chills*	☐ *Bleed easily*
☐ *Heavy appetite*	☐ *Heavy sleep*	☐ *Cold hands/feet*	☐ *Night sweats*	☐ *Peculiar taste*
☐ *Like cold drink*	☐ *Fever*	☐ *Poor circulation*	☐ *Sweat easily*	☐ *Like hot drinks*
☐ *Fatigue*	☐ *Shortness of breath*	☐ *Muscle cramps*	☐ *Vertigo/dizziness*	☐ *Lack of strength*
☐ *Recent weight loss/gain*		☐ *Dream disturbed sleep*		

Head, Eyes, Ears, Nose, Throat

☐ *Glasses*	☐ *Night blindness*	☐ *Sores*	☐ *Sore throat*	☐ *Headaches*
☐ *Eye strain*	☐ *Glaucoma*	☐ *Dry mouth*	☐ *Swollen glands*	☐ *Lump in throat*
☐ *Eye pain*	☐ *Cataracts*	☐ *Excessive saliva*	☐ *Sinus problems*	☐ *Migraines*
☐ *Red eyes*	☐ *Teeth problems*	☐ *Excessive phlegm*	☐ *Nose bleeds*	☐ *Gum problems*
☐ *Itchy eyes*	☐ *Grinding teeth*	☐ *Ringing in ears*	☐ *Concussions*	☐ *Poor hearing*
☐ *Spots on eyes*	☐ *Earaches*	☐ *TMJ*	☐ *Facial pain*	☐ *Lumps in throat*
☐ *Poor vision*	☐ *Enlarged thyroid*	☐ *Blurred vision*		

Respiratory

☐ *Difficulty breathing when lying down*	☐ *tightness in chest* ☐ *Asthma/wheezing*	☐ *Cough* ☐ *wet* ☐ *dry*	☐ *Color of Phlegm* _____	☐ *Coughing blood* ☐ *Pneumonia*
☐ *Shortness of breath*				

Cardiovascular

☐ *High blood pressure*	☐ *Low blood pressure*	☐ *Chest pain*	☐ *Tachycardia*	☐ *Phlebitis*
☐ *Blood clots*	☐ *Fainting*	☐ *Difficulty breathing*	☐ *Heart palpitations*	☐ *Irregular heartbeat*

Gastrointestinal

☐ *Nausea*	☐ *Diarrhea*	☐ *Vomiting*	☐ *Bowel movements:*
☐ *Constipation*	☐ *Itchy anus*	☐ *Burning anus*	*frequency*_____
☐ *Acid regurgitation*	☐ *Laxative use*	☐ *Gas*	*color*_____
☐ *Black stool*	☐ *Bloody stool*	☐ *Rectal pain*	*texture/form*_____
☐ *Hiccups*	☐ *Bloating*	☐ *Mucous in stool*	☐ *Bad breath*

Musculoskeletal

☐ *Neck/shoulder pain*	☐ *Upper back pain*	☐ *Joint pain*	☐ *Limited range of motion*
☐ *Muscle pain*	☐ *Lower back pain*	☐ *Rib pain*	☐ *limited use* _____

Skin and Hair

☐ *Rashes*	☐ *Eczema*	☐ *Dandruff*	☐ *Hives*	☐ *Itching*
☐ *Fungal infections*	☐ *Ulcerations*	☐ *Hair loss*		

Neuropsychological

☐ *Seizures*	☐ *Poor memory*	☐ *Irritability*	☐ *Attempt/consider suicide*
☐ *Numbness*	☐ *Depression*	☐ *Easily stressed*	☐ *Tics*
☐ *Anxiety*	☐ *Abuse survivor*	☐ *Seeing a therapist*	☐ *Other*_____

Genital-urinary

☐ *Pain urinating*	☐ *Blood in urine*	☐ *Venereal disease*	☐ *Kidney stone*	☐ *Increased libido*
☐ *Frequent urination*	☐ *Incontinence*	☐ *Bed wetting*	☐ *Wake to urinate*	☐ *Decreased libido*
☐ *Urgent urination*	☐ *Nocturnal emission*	☐ *Premature ejaculation*		☐ *Impotence*

Gynecology

☐ *Age menstrual cycle began*_____	☐ *Duration of flow* _____	☐ *Vaginal discharge color*_____	☐ *Breast lumps* *# pregnancies* _____	☐ *Date of last PAP* _____
☐ *length of cycle* _____	☐ *Painful periods* ☐ *Irregular periods* ☐ *PMS*	☐ *Vaginal sores* ☐ *Vaginal odor* ☐ *Clots*	*# live births* _____ *Premature* _____ *Age at menopause*_____	☐ *Date of last period*

Other:_____

_____

_____