

Patient Health History

Please complete this form to the best of your ability.
Some of the questions may seem unrelated to the condition for which you are being treated, however, they may assist the practitioner in developing a precise diagnosis and treatment plan.

Kindly Print the Information

Name: _____ DOB: _____ Age: _____

Address: _____

City / State / Zip: _____

How may we contact you? If by phone, is it ok to leave a message? yes _____ no _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Are you under a medical doctor's care for any specific physical or mental condition? yes _____ no _____

If yes, is it related to the purpose of today's visit? yes _____ no _____

Please list the reason(s), in order of importance, that you wish to see an acupuncturist for:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

HISTORY OF YOUR CONDITION: _____

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Allergies to Medications: _____

Other Allergies or Intolerances: _____

Medications / Vitamins /Supplements / Herbs List:

MEDICAL HISTORY

Please name diseases/problems with the following:

Heart _____ Mental Health _____
Lungs _____ Skin _____
Bowels/Stomach _____ Hair _____
Kidneys _____ Teeth _____
Eyes/Ear/Nose/Throat _____

Chronic / Systemic (check all that apply):

_____ Diabetes _____ Cancer _____ Chronic Fatigue Syndrome
_____ Lupus _____ Thyroid Disease _____ Fibromyalgia
_____ Systemic Infections _____ Rheumatoid Arthritis _____ EBV
_____ Lyme's Disease _____ Adrenal _____ MS
_____ HIV _____ AIDS _____ ALS

Other: _____

FAMILY MEDICAL HISTORY:

Mother's Side: _____ Father's Side: _____

Are you Adopted: Yes _____ No _____

Surgeries (also dental) & approximate dates:

Significant Trauma (in injuries, accidents) & dates:

Significant Toxic Exposure (household cleaning products, hair/ skin care products, tainted water supply, chemical spills) at home, on the job, in the neighborhood:

FEMALE MEDICAL HISTORY

_____ Pregnancies _____ Premature Births _____ Age at First Period
_____ Miscarriages _____ Abortions _____ Age of Menopause

If you have in the past or are now taking birth control pills or hormone replacement therapy, please list under **Medications** on page two of this questionnaire.

Do you have fertility problems? If yes, please explain: _____

Do you have any concerns with the following vaginal symptoms:

_____ Odor _____ Sores _____ Dryness _____ Soreness/Pain During Intercourse

When was the first day of your last period? _____

Do you bleed every month with your menses? _____

If no, how often does your menses occur? _____

How many days does your bleeding last? _____

Do you have any of the following associated with your period?

_____ Breast Tenderness/Soreness _____ Breast Distention _____ Excessive Bleeding
_____ Breast Masses _____ Mood Swings _____ Irritability
_____ Weepiness _____ Food Cravings _____ Taste / Smell Changes
_____ Painful Cramps Other Pain _____

What, if anything, makes the above symptoms feel better or worse:

FEMALE MEDICAL HISTORY (continued)

Do you or did you ever have these symptoms related to menopause:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Taste / Smell Changes | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Elation | |

Other: _____

MALE MEDICAL HISTORY

Are you currently experiencing or have experienced in the past any of the following (please explain):

Prostrate Problems: _____

Fertility Problems: _____

Testicular Problems: _____

If patient is under the age of 17, she or he must be accompanied by a parent or legal guardian whose signature is required by law.

_____	_____
Patient Signature	Date

_____	_____
Guardian Signature	Date