
# Medical History

Confidential

## General Information

Patient Name_____
Patient Address_____
City_____State_____Zip_____
Home Phone _____Work Phone_____
Gender ❑ Male ❑ Female Age_____ DOB ____/____/_____ Weight_____
Marital Status_____Occupation_____

Primary Practitioner (Medical Doctor)_____Date of last visit____/____/____
Reason for Visit_____

Have you received acupuncture/Chinese Herbs in the past? ❑ Yes ❑ No
Name of Acupuncturist _____Date of last visit____/____/____
Reason for Visit_____

## Emergency Contact

Name_____Relationship_____
Address_____Phone_____

## Major Concern

What is your primary reason for this visit?_____
_____
_____

This condition is due to ❑ Automobile Injury ❑ Work Injury ❑ Sports Injury ❑ Illness ❑ Not sure ❑ Other
If Other, please explain_____

What was the date of the illness or injury?____/____/____ When did your symptoms begin?____/____/____

Did your symptoms develop? ❑ Gradually or ❑ Suddenly How long do symptoms last?_____

Is there a pattern to when your symptoms occur? ❑ Yes ❑ No
if yes, what is the pattern? ❑ In the morning ❑ Occasionally ❑ During sleep
❑ In the evening ❑ Intermittently ❑ Upon waking
❑ All day ❑ Constantly ❑ Other_____
_____

What initiates your symptoms?_____
What makes them worse?_____
What makes them better?_____
Have you received treatment for this concern? ❑ yes ❑ no
If yes, what was done and did it help?_____

Do you have specific questions you would like to discuss today?_____
_____
_____

## Family History

Father ❑ Living Age_____ ❑ Deceased Age at Death_____ Cause_____
Mother ❑ Living Age_____ ❑ Deceased Age at Death_____ Cause_____
Spouse ❑ Living Age_____ ❑ Deceased Age at Death_____ Cause_____
Siblings Gender ❑ Male ❑ Female Health Status_____
Gender ❑ Male ❑ Female Health Status_____
Children Gender ❑ Male ❑ Female Health Status_____
Gender ❑ Male ❑ Female Health Status_____

Check illness(es) which have occurred in any of your blood relatives
❑ Alcoholism ❑ Bleed Easily ❑ Diabetes ❑ Heart Disease ❑ Kidney Disease ❑ Obesity ❑ Allergy ❑ Cancer
❑ Epilepsy ❑ High Blood Pressure ❑ Mental Illness ❑ Stroke ❑ Other_____

## Personal History

How would you describe your health as a child?_____
_____

Check any illnesses or conditions you have had in the past.

| | | |
|---|---|---|
| ❑ Alcoholism | ❑ Hepatitis | ❑ Pacemaker |
| ❑ Allergies | ❑ High Blood Pressure | ❑ Pneumonia |
| ❑ Antibiotic Use | ❑ High Fevers | ❑ Polio |
| ❑ Asthma | ❑ HIV/AIDS | ❑ Stroke |
| ❑ Bleed Easily | ❑ Jaundice | ❑ Thyroid Disorders |
| ❑ Cancer | ❑ Kidney Disease | ❑ Tuberculosis |
| ❑ Chicken Pox | ❑ Measles | ❑ Typhoid Fever |
| ❑ Diabetes | ❑ Meningitis | ❑ Ulcers |
| ❑ Epilepsy | ❑ Mental Disorder | ❑ Vascular Disease |
| ❑ Glaucoma | ❑ Multiple Sclerosis | ❑ Venereal Disease |
| ❑ Heart Disease | ❑ Mumps | ❑ Other: _____ |

List illnesses not requiring surgery for which you have been hospitalized_____
_____

List illnesses requiring surgery (include dates)_____
_____

List any other serious injury, broken bones, scars, etc._____
_____

List allergies or sensitivities to medications or other substances_____
_____

List date and results of last medical test (ie: physical, cholesterol, hepatitis, mammography, stool, HIV test, PSA (prostate), Pap smear, or other)
Date____/_____/____ Test_____ Result_____
Date____/_____/____ Test_____ Result_____
Date____/_____/____ Test_____ Result_____
Date____/_____/____ Test_____ Result_____

Anything else you would like to tell us?_____
_____
_____