

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.

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

