

ORIENTAL MEDICAL HISTORY

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.
All of your answers will be held absolutely confidential. If you have any questions, please ask.

NAME _____		EMAIL _____		Date _____	
HOME PHONE _____		CELL _____		WORK _____	
ADDRESS _____		City _____		State _____ Zip _____	
DATE OF BIRTH _____		AGE _____		HEIGHT _____ WEIGHT _____	
MARITAL STATUS _____		# OF CHILDREN & AGES _____			
OCCUPATION _____		SSN _____			
EMPLOYER _____					
INSURANCE CO. _____					
MEMBER ID _____		PHONE # _____			
NAME POLICY IS UNDER _____		GROUP # _____			
WHOM MAY WE THANK FOR REFERRING YOU? _____					
HAVE YOU EVER HAD ACUPUNCTURE OR ORIENTAL MEDICINE TREATMENT BEFORE? _____					
IN CASE OF EMERGENCY CONTACT _____					
ADDRESS _____		PHONE _____			

CHIEF COMPLAINT (please describe in your own words what you experience)

Diagnosis by an MD? What? _____

When did this problem begin? _____

Characteristics? _____ How often? _____

What makes it feel better? _____ Worse? _____

What other forms of treatment have you sought? _____

List any other health problems you now have _____

List any allergies, food sensitivities or food cravings you have

Have you had your tonsils removed? _____ Appendix? _____ Gall Bladder? _____

Have you had oral surgery? _____ Please list _____

Have you ever taken antibiotics for more than 10 days? _____ When and for what? _____

Do you have a pacemaker? _____ Taking Coumadin/Warfarin? _____ Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)? _____

Have you ever had chemotherapy? _____ When? _____ Radiation Therapy? _____ When? _____

Are you current under the care of a physician or a therapist? _____

What are you being treated for? _____

Have you recently had any unusually stressful experiences (i.e. divorce, death of someone close, bankruptcy, loss of job, illness, injury, etc)? Please list: _____

What type of exercise do you get and how often? _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

Snacks _____

Please list any dietary restrictions _____

How much of the following do you drink per day? Coffee (cups) _____ Tea (cups) _____

Water (oz) _____ Soft Drinks (cans) _____ Wine (glass) _____ Beer (oz) _____ Liquor (oz) _____

Hospitalizations/Surgeries (Please include dates): _____

Please list all current medications. You may use the back of this sheet:

Medicine	Dosage	Reason	How long?

Have you ever been alcohol or drug dependent? When? _____

How much tobacco do you use per day? _____ Marijuana? _____ Other _____

Family Medical History Please check the diseases which **other members** of your family had:

<input type="checkbox"/> Cancer _____ Who?	<input type="checkbox"/> Heart Disease _____ Who?	<input type="checkbox"/> Asthma _____ Who?
<input type="checkbox"/> Diabetes _____ Who?	<input type="checkbox"/> Alcoholism _____ Who?	<input type="checkbox"/> Stroke _____ Who?
<input type="checkbox"/> Arthritis _____ Who?	<input type="checkbox"/> Hypertension _____ Who?	_____ Other

Which of the following diseases have **you** had?

<input type="checkbox"/> mumps	<input type="checkbox"/> allergies	<input type="checkbox"/> gonorrhea	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> ear infections	<input type="checkbox"/> asthma	<input type="checkbox"/> genital herpes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> measles	<input type="checkbox"/> oral thrush	<input type="checkbox"/> genital warts	<input type="checkbox"/> ARC
<input type="checkbox"/> chicken pox	<input type="checkbox"/> oral herpes	<input type="checkbox"/> chlamydia	<input type="checkbox"/> HIV +

SYMPTOM SURVEY

The following is a list of symptoms that you may or may not experience. Please indicate as follows:
 leave blank if never experience check mark (a) if sometimes experience plus sign (+) if always experience

<input type="checkbox"/> lack of appetite	<input type="checkbox"/> insomnia, difficulty sleeping	<input type="checkbox"/> low back pain
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> heart palpitations	<input type="checkbox"/> knee problems
<input type="checkbox"/> loose stool or diarrhea	<input type="checkbox"/> cold hands and feet	<input type="checkbox"/> hearing impairment
<input type="checkbox"/> constipation	<input type="checkbox"/> nightmares	<input type="checkbox"/> ear ringing
<input type="checkbox"/> difficulty digesting oily foods	<input type="checkbox"/> mentally restless	<input type="checkbox"/> kidney stones
<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> laughing for no apparent reason	<input type="checkbox"/> decreased sex drive
<input type="checkbox"/> vomiting	<input type="checkbox"/> angina pains	<input type="checkbox"/> increased sex drive
<input type="checkbox"/> abdominal pain	<input type="checkbox"/> anxiety attacks	<input type="checkbox"/> hair loss
<input type="checkbox"/> digestive problems	<input type="checkbox"/> manic episodes	<input type="checkbox"/> urinary problems
<input type="checkbox"/> colitis or diverticulitis	<input type="checkbox"/> poor memory	<input type="checkbox"/> fearful
<input type="checkbox"/> indigestion	<input type="checkbox"/> difficulty concentrating	<input type="checkbox"/> pain or coldness in the genital area
<input type="checkbox"/> belching, burping	<input type="checkbox"/> frequent crying	<input type="checkbox"/> fatigue
<input type="checkbox"/> recent use of antibiotics	<input type="checkbox"/> dry eyes	<input type="checkbox"/> edema
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> dry hair	<input type="checkbox"/> blood in stool
<input type="checkbox"/> feeling retention of food in the stomach	<input type="checkbox"/> dry skin	<input type="checkbox"/> black tarry stool
<input type="checkbox"/> tendency to become obsessive or compulsive	<input type="checkbox"/> dry mouth	<input type="checkbox"/> easily bruised
<input type="checkbox"/> cough	<input type="checkbox"/> eye problems	<input type="checkbox"/> difficult to stop bleeding
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> jaundice	<input type="checkbox"/> dizziness
<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> gall stones	<input type="checkbox"/> tendency to faint easily
<input type="checkbox"/> nasal problems	<input type="checkbox"/> light colored stools	<input type="checkbox"/> high cholesterol levels
<input type="checkbox"/> asthma	<input type="checkbox"/> soft or brittle nails	<input type="checkbox"/> sudden weight loss
<input type="checkbox"/> allergies	<input type="checkbox"/> easily angered or agitated	<input type="checkbox"/> sadness or grief
<input type="checkbox"/> hay fever	<input type="checkbox"/> difficulty in making plans or decisions	<input type="checkbox"/> thirsty
<input type="checkbox"/> feelings of claustrophobia	<input type="checkbox"/> spasms or twitching of muscles	<input type="checkbox"/> prefer hot drinks
<input type="checkbox"/> bronchitis	<input type="checkbox"/> irritability or easily angered	<input type="checkbox"/> prefer cold drinks
<input type="checkbox"/> tendency to catch colds easily	<input type="checkbox"/> breast lumps	<input type="checkbox"/> thyroid disorders
<input type="checkbox"/> intolerance to weather changes	<input type="checkbox"/> depression	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> headaches	<input type="checkbox"/> PMS	<input type="checkbox"/> tremors
		<input type="checkbox"/> chest pain
		<input type="checkbox"/> sciatic pain

MUSCULOSKELETAL

Pain or numbness in any of the following areas - if pain, please rate levels using a scale from 0-10, 0 is the least and 10 is the worst.

- | | | |
|---------------------|--------------------------|---------------------------------|
| ___ neck | ___ leg or calf cramping | ___ poor posture |
| ___ shoulders | ___ muscle weakness | ___ sciatica |
| ___ arms/elbows | ___ muscle spasms | ___ low back pain |
| ___ wrist/hands | ___ rheumatoid arthritis | ___ swollen joints |
| ___ knees | ___ bursitis | ___ numbness in toes |
| ___ feet | ___ thighs | ___ numbness in fingers |
| ___ spinal stenosis | ___ legs | ___ degenerative joint disorder |
| ___ scoliosis | ___ calves | ___ degenerative disc |

What relieves your pain/condition?

Heat ___ Cold ___ Damp ___ Weather ___ Wind ___ Medications ___ Pressure ___

What aggravates your pain/condition?

Heat ___ Cold ___ Damp ___ Weather ___ Wind ___ Medications ___ Pressure ___

FOR WOMEN

Age of 1st period(menarche) _____

Age of last period(menopause) _____

Number of days between periods _____

Number of days of flow _____

Color of flow _____

Clots? _____ Color _____

Avg # of pads per day 1st day _____ 2nd day _____

3rd day _____ 4th day _____ 5th day _____ +days _____

Cramps _____ When _____

Location _____

Nature and at what time of period?

cramping _____ stabbing _____

burning _____ aching _____

dull _____ bloating _____

consistent _____ intermittent _____

Are you pregnant? _____ Trying? _____

of pregnancies _____ miscarriages _____

of live births _____ # of abortions _____

Date of last obgyn exam + results _____

Pap _____

Smear _____ Mammogram _____

Bone Density Scan _____

Other symptoms related to menses:

___ discharge ___ vaginal dryness ___ headache

___ nausea ___ constipation ___ swollen breasts

___ diarrhea ___ ravenous appetite ___ insomnia

___ hot flashes ___ poor appetite ___ libido

___ libido ___ night sweats ___ mood swings

Have you been diagnosed with (include year):

_____ fibroids _____ endometriosis _____ PID

_____ Ovarian cysts _____ fibrocystic breasts

FOR MEN

Date of last prostate exam _____ PSA results _____ Manual prostate exam results _____

Frequency of urination: daytime _____ nighttime _____ color of urine _____ odor _____

Symptoms related to prostate:

___ prostate problems ___ delayed stream ___ dribbling ___ incontinence ___ retention of urine ___ impotence

___ groin pain ___ testicular pain ___ premature ejaculation ___ back pain ___ 5libido ___ 6libido ___ rectal

dysfunction

Other _____