

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.

PERSONAL INFORMATION:

TODAY'S DATE _____

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

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

When did this problem begin? _____
Diagnosis by an MD? _____
Lab results for the above _____
Characteristics? _____
How often? _____
What makes it feel better? _____ Worse? _____
What other forms of treatment have you sought? _____

Hospitalizations/Surgeries (Please include dates): _____

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 _____

When was the last time you have taken antibiotics? _____

Do you have a pacemaker? _____ Taking Coumadin/Warfarin? _____

Are you taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)? _____

When and for how long? _____

Have you ever had chemotherapy? _____

Radiation Therapy? _____

Are you current under the care of a physician? _____

Or a therapist? _____

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

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

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

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

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) _____

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

__ Cancer _____ Who? __ Heart Disease _____ Who? __ Asthma _____ Who?

__ Diabetes _____ Who? __ Alcoholism _____ Who? __ Stroke _____ Who?

__ Arthritis _____ Who? __ Hypertension _____ Who? _____ Other

Which of the following diseases have you had?

__ mumps __ allergies __ gonorrhea __ Hepatitis C
__ ear infections __ asthma __ genital herpes __ Tuberculosis
__ measles __ oral thrush __ genital warts __ ARC
__ chicken pox __ oral herpes __ chlamydia __ 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 (✓) if sometimes experience, plus sign (+) if always experience

- lack of appetite
- excessive appetite
- loose stool or diarrhea
- constipation
- difficulty digesting oily foods
- hemorrhoids
- vomiting
- abdominal pain
- digestive problems
- colitis or diverticulitis
- indigestion
- belching, burping
- recent use of antibiotics
- heartburn/reflux
- feeling retention of food in the stomach
- tendency to become obsessive or compulsive

- insomnia, difficulty sleeping
- heart palpitations
- cold hands and feet
- nightmares
- mentally restless
- laughing for no apparent reason
- angina pains
- anxiety attacks
- manic episodes
- poor memory
- difficulty concentrating
- frequent crying
- dry eyes
- dry hair
- dry skin
- dry mouth

- low back pain
- knee problems
- hearing impairment
- ear ringing
- kidney stones
- decreased sex drive
- increased sex drive
- hair loss
- urinary problems
- fearful
- pain or coldness in the genital area

- cough
- shortness of breath
- decreased sense of smell
- nasal problems
- asthma
- allergies
- hay fever
- feelings of claustrophobia
- bronchitis
- tendency to catch colds easily
- intolerance to weather changes
- headaches

- eye problems
- jaundice
- gall stones
- light colored stools
- soft or brittle nails
- easily angered or agitated
- difficulty in making plans or making decisions
- spasms or twitching of muscles
- irritability
- breast lumps
- depression
- PMS

- fatigue
- edema
- blood in stool
- black tarry stool
- easily bruised
- difficult to stop bleeding
- dizziness
- tendency to faint easily
- high cholesterol levels
- sudden weight loss
- sadness or grief
- thirsty
- prefer hot drinks
- prefer cold drinks
- thyroid disorders
- high blood pressure
- tremors
- chest pain
- sciatic pain

MUSCULOSKELETAL

Pain or numbness in any of the following areas

- for pain, please rate levels using a scale from 0-10, 0 is no pain and 10 is the worst.

- neck
- shoulders
- arms/elbows
- wrist/hands
- knees
- feet
- spinal stenosis
- scoliosis

- leg or calf cramping
- muscle weakness
- muscle spasms
- rheumatoid arthritis
- bursitis
- thighs
- legs
- calves

- poor posture
- sciatica
- low back pain
- swollen joints
- numbness in toes
- numbness in fingers
- degenerative joint disorder
- 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 _____

List any medications, vitamins, herbs, homeopathics and supplements you are currently taking:(continue on back if needed)

Medicine	Dosage	Reason	How Long

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 _____
 Do you use pads or tampons? (circle one or both)
 Avg # per day Day 1 _____ Day 2 _____ Day 3 _____
 Day 4 _____ Day 5 _____ Day 6 _____ +Days _____

Cramps

Nature of your cramps and at what time of the cycle?
 cramping _____ stabbing _____
 burning _____ aching _____
 dull _____ bloating _____
 consistent _____ or intermittent _____
 What relieves your cramping? _____

Date of last period _____

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 ___ dec. libido ___ Inc. libido ___ rectal dysfunction

Other _____