

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? _____

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:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Who?	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Who?	<input type="checkbox"/> Asthma	<input type="checkbox"/> Who?
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Who?	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Who?	<input type="checkbox"/> Stroke	<input type="checkbox"/> Who?
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Who?	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Who?	_____	<input type="checkbox"/> 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 (✓) 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"/> recent use of antibiotics | <input type="checkbox"/> dry eyes | |
| <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> dry hair | |
| <input type="checkbox"/> feeling retention of food in the stomach | <input type="checkbox"/> dry skin | |
| <input type="checkbox"/> tendency to become obsessive or compulsive | <input type="checkbox"/> dry mouth | |
| | | <input type="checkbox"/> fatigue |
| | | <input type="checkbox"/> edema |
| | | <input type="checkbox"/> blood in stool |
| | | <input type="checkbox"/> black tarry stool |
| | | <input type="checkbox"/> easily bruised |
| | | <input type="checkbox"/> difficult to stop bleeding |
| <input type="checkbox"/> cough | <input type="checkbox"/> eye problems | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> jaundice | <input type="checkbox"/> tendency to faint easily |
| <input type="checkbox"/> decreased sense of smell | <input type="checkbox"/> gall stones | <input type="checkbox"/> high cholesterol levels |
| <input type="checkbox"/> nasal problems | <input type="checkbox"/> light colored stools | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> asthma | <input type="checkbox"/> soft or brittle nails | <input type="checkbox"/> sadness or grief |
| <input type="checkbox"/> allergies | <input type="checkbox"/> easily angered or agitated | <input type="checkbox"/> thirsty |
| <input type="checkbox"/> hay fever | <input type="checkbox"/> difficulty in making plans or making decisions | <input type="checkbox"/> prefer hot drinks |
| <input type="checkbox"/> feelings of claustrophobia | <input type="checkbox"/> spasms or twitching of muscles | <input type="checkbox"/> prefer cold drinks |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> irritability | <input type="checkbox"/> thyroid disorders |
| <input type="checkbox"/> tendency to catch colds easily | <input type="checkbox"/> breast lumps | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> intolerance to weather changes | <input type="checkbox"/> depression | <input type="checkbox"/> tremors |
| <input type="checkbox"/> headaches | <input type="checkbox"/> PMS | <input type="checkbox"/> chest pain |
| | | <input type="checkbox"/> 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.

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