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Date ____________

Medical History Form

Please help me provide you with a complete evaluation by taking the time to fill out this form thoroughly. This information is held in confidence. If you have any questions, please ask. If there is anything you wish to bring to my attention which is not asked on this form, please note it in the Comments section at the end. Thank you for your help.

Name _________________________________ Date of Birth ________________ Age ______
Address _______________________________ Height _______ Weight _______ Sex ______
_______________________________ Occupation _____________________________
Phone (H) __________________ (W) ______________________ (C) ____________________
Email ________________________________ Would you like to receive my email newsletter?
Referred by ___________________________ Marital status □ S □ M □ D □ W □ P
Physician _____________________________ Spouse/Partner's Name ___________________
Physician Phone # ______________________ Emergency Contact ______________________
Physician Address ______________________ Relationship __________ Phone ____________

Have you ever received acupuncture before? ___ For what reason? ________________________
What is the chief health issue you'd like to have treated? ________________________________
When did the problem begin? ____
To what extent does it interfere with your daily life? ____________________________________
Secondary issue(s) you would like to address ____
If you have been given a medical diagnosis for the main problem, please state _______________
____
What treatment(s) have you been using for relief of this issue? ____________________________
What other therapies are you currently using? ____

Surgeries or hospitalizations (include dates) ____
____

Significant traumas or accidents (include dates) ____
____

Allergies (foods, medications, pollen, etc.) ____

Medications/vitamins/supplements you are taking ____
____

Occupational stress (chemical, physical, psychological) ___________________________________
____

Family Medical History – please note which blood relative has had the following:

Allergies	________________	Drug/Alcohol Abuse	______________	Seizures	_________________
Asthma	________________	Epilepsy	________________________	Stroke	___________________
Cancer	________________	Heart Disease	___________________	Thyroid Disease	___________
Diabetes	________________	High Blood Pressure	______________	Other	____________________

Habits and Lifestyle

Do you practice any form of relaxation/meditation techniques? _____________________________

____

Please describe the types of foods you eat daily:

Morning ____

Midday ____

Evening ____

Snacks ____

What foods or tastes do you crave most? ____

How much liquid do you drink in a day?______________ How much of that is water? __________

Do you use tobacco now? ______ In the past? _____ Amount: ____________________________

Do you drink alcohol now? _____ In the past? _____ Amount: ___________________________

Do you drink caffeinated beverages (coffee, tea, cola, etc.) now? ____ In the past? _____

Type and weekly amount: ____

Do you use any other drugs on a regular basis now? _________ In the past? ________________

Do you suffer from any of the following conditions?

please check all that apply

General

Past Current

- □ □ Catch cold easily
- □ □ Recurrent infections
- □ □ Night sweats
- □ □ Sweat easily
- □ □ Bleed or bruise easily
- □ □ Strong thirst (□ hot □ cold)
- □ □ Thirst, no desire to drink
- □ □ Fatigue/low energy
- □ □ Sudden energy drops (time of day ______)
- □ □ Sudden change in weight

Skin /Hair

Past Current

- □ □ Dry skin/scalp/hair
- □ □ Rashes/hives
- □ □ Itching
- □ □ Eczema
- □ □ Warts
- □ □ Acne
- □ □ Changes in moles
- □ □ Hair loss/thinning hair
- □ □ Graying of hair
- □ □ Other _______________________

Sleep

Past Current

- □ □ Difficulty falling asleep
- □ □ Wake up during night (times per night ____)
- □ □ Wake early in morning (what time? ______)
- □ □ Nightmares/bad dreams
- □ □ Vivid dreams
- □ □ Grinding teeth
- □ □ Talking in sleep
- □ □ Sleepwalking
- □ □ Snoring

Head/Eyes/Ears/Nose/Throat

Past Current

- □ □ Headaches
  - Where _____________________
  - When _____________________
- □ □ Migraines
- □ □ Dizziness/vertigo
- □ □ Earache
- □ □ Discharge from ear
- □ □ Change in hearing
- □ □ Ringing in ears

Head/Eyes/Ears/Nose/Throat, cont.

Past Current

- □ □ Blurry vision
- □ □ Night blindness
- □ □ Color blindness
- □ □ Spots before eyes
- □ □ Sore eyes
- □ □ Eye pain
- □ □ Excessive tearing
- □ □ Glasses/contacts
- □ □ Facial pain
- □ □ Facial paralysis
- □ □ Nosebleeds
- □ □ Nasal discharge
- □ □ Post-nasal drip
- □ □ Stuffy nose
- □ □ Sinusitis
- □ □ TMJ
- □ □ Teeth/gum problems
- □ □ Teeth grinding
- □ □ Recurrent sore throat
- □ □ Hoarseness/loss of voice
- □ □ Tonsillitis/swollen glands
- □ □ Sores on lips/mouth/gums
- □ □ Other ____________________

Respiratory

Past Current

- □ □ Pain with breathing
- □ □ Difficulty breathing
- □ □ Shallow breathing
- □ □ Shortness of breath
- □ □ Production of phlegm
- □ □ Recurrent/chronic cough
- □ □ Coughing blood
- □ □ Asthma/wheezing
- □ □ Bronchitis
- □ □ Emphysema
- □ □ Pneumonia
- □ □ Other ____________________

Cardiovascular

Past Current

- □ □ High blood pressure
- □ □ Low blood pressure
- □ □ Irregular heart beat
- □ □ Heart palpitations
- □ □ Chest discomfort/pain
- □ □ Cold hands or feet
- □ □ Swelling of hands or feet
- □ □ Blood clots

Cardiovascular, cont.

Past Current

- □ □ Dizzy or faint when stand quickly
- □ □ Varicose or spider veins
- □ □ Other ______________________

Digestive

Past Current

- □ □ Little appetite
- □ □ Strong appetite
- □ □ Hunger with no desire to eat
- □ □ Bad breath
- □ □ Belching
- □ □ Nausea
- □ □ Vomiting
- □ □ Heartburn
- □ □ Indigestion
- □ □ Abdominal pain/cramps
- □ □ Weight gain
- □ □ Weight loss
- □ □ Ulcer
- □ □ Hernia
- □ □ Strong-smelling stools
- □ □ Bloody stools
- □ □ Pale stools
- □ □ Black stools
- □ □ Diarrhea/loose stools
- □ □ Constipation
    - □ dry stools
    - □ not daily
    - □ with difficulty
- □ □ Pain with bowel movement
- □ □ Gas/flatulence
- □ □ Hemorrhoids
- □ □ Rectal pain
    - □ □ Diverticulitis
- □ □ Laxative use
- □ □ Crohn’s disease
- □ □ Irritable Bowel Syndrome
- □ □ Anorexia
- □ □ Bulimia
- □ □ Other ______________________

Genito-urinary

Past Current

- □ □ Pain on urination
- □ □ Urgent urination
- □ □ Frequent urination
- □ □ Blood in urine
- □ □ Cloudy urine
- □ □ Change in urinary flow

Genito-urinary, cont.

Past Current

□ □ Urinary incontinence
□ □ Incontinence at night
□ □ Dribbling urination
□ □ Waking at night to urinate
How often? _____
□ □ Recurrent bladder infections
□ □ Recurrent yeast infections
□ □ Kidney stones
□ □ Rashes/itching
□ □ Other ____________________

Women – Gynecologic and Reproductive

Past Current

□ □ Irregular periods
□ □ Menstrual problems
□ Bloating
□ Breast tenderness
□ Cramps
□ Emotional changes
□ □ Premenstrual symptoms
□ □ Menopausal symptoms
□ □ Abnormal bleeding
□ □ Abnormal PAP smear
□ □ Postcoital bleeding
□ □ Clots
□ □ Fibroids
□ □ Endometriosis
□ □ Infertility
□ □ Vaginal dryness
□ □ Vaginal discharge
□ □ Breast lumps
□ □ Nipple discharge
□ □ Low libido
□ □ Itching of vulva
□ □ Other ____________________

Are you now pregnant?
□ no □ yes; # of weeks _______
Do you practice birth control?
□ no □ yes
what type & how long? ________

pregnancies ____
births _________
abortions ______
miscarriages ___
stillbirths ______

Women – Gynecologic, cont.

Age of first menses ___________
days between menses ________
duration of menses ____________
Age of menopause ____________
Do you take hormone replacements?
□ no □ yes

Men - Reproductive

Past Current

□ □ Prostate problems
□ □ Low libido
□ □ Impotence
□ □ Infertility
□ □ Penis discharge
□ □ Premature ejaculation
□ □ Vasectomy (date ________)
□ □ Other ____________________

Musculoskeletal

Past Current

□ □ Neck pain
□ □ Shoulder pain
□ □ Back pain
□ □ Hand/wrist pain
□ □ Hip pain
□ □ Knee pain
□ □ Foot/ankle pain
□ □ Joint/bone problems
□ □ Muscle pain/weakness
□ □ Herniated disk
□ □ Sciatica
□ □ Scoliosis
□ □ Fibromyalgia
□ □ Other ______________________

Neurological

Past Current

□ □ Dizziness/vertigo
□ □ Loss of balance
□ □ Lack of coordination
□ □ Numbness/tingling
□ □ Concussion
□ □ Paralysis
□ □ Seizures
□ □ Tremors
□ □ Nerve damage
□ □ Other ______________________