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 # _____
Do you require language assistance? Yes____ No____
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:

__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 (a) 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

__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

__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

__eye problems
__jaundice
__gall stones
__light colored stools
__soft or brittle nails
__easily angered or agitated
__difficulty in making plans or decisions
__spasms or twitching of muscles
__irritability or easily angered
__breast lumps
__depression
__PMS

__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

__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 - if pain, please rate levels using a scale from 0-10, 0 is the least 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____

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_____

_____