

Medical History Form

Welcome! The following is a list of questions pertaining to a Chinese Medical Diagnosis. Please be complete and honest with your answers and make sure to fill out the form completely. Thank you!

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name _____ Date of Birth _____
Street Address _____ City _____ State _____
Zip _____
Work Phone _____ Home phone _____ Cell Phone/pager _____
Emergency Contact Name: _____ Phone: _____
Employer _____ SSN: _____
Occupation/employer _____

How did you hear about AA Acupuncture?

Google ___ Yahoo ___ City Search ___ Dex Online ___
Online Yellow Pages ___ Other Online Search (specify) _____
Yellow Pages _____ Friend ___ Family ___ Radio or TV? (Which One?) _____
Insurance Company(Which One) _____ Other _____

Please describe the reason for your visit today: (Chief complaint) _____

Is it getting better, worse, or unchanged? _____

Are you, or have you been, treated for this problem by any other health professionals? If so, where and by whom? _____

Has it been effective? _____

What was your diagnosis? _____

Has your case been referred to an attorney? Y N

Do you currently see any other health care professionals? Y N If so, please list:

If you are female, do you have any reason to believe that you are pregnant? Y N

Do you have any chronic infectious diseases? (For example, Hep B, Hep C, HIV, AID's, etc) Y N

If so, please explain: _____

Are you currently suffering from a chronic illness? Y N If so, please explain:

Are you taking any medication or herbal supplements? Y N If so, which ones? (Add dosage if known) _____

Please list any foods, drugs, or medications you are hypersensitive or allergic to: (Please list the type of reaction) _____

Are you in generally good health, or do you frequently fall ill? _____

What illnesses might you be prone to? (i.e., frequent colds, Gastro-intestinal problems) _____

MEDICAL HISTORY

General:

Height: _____ Weight: (Currently) _____ (Past Maximum Weight) _____ When? _____
What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Childhood Illnesses: Please circle any that you have had:

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox Meningitis (Viral/Bacterial) Polio Scarlet Fever Other:

Immunizations: Please circle which ones you have had:

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Other:

Have you ever been hospitalized or had any surgical procedures? If so please list the reason and the date.

Have you ever had any X-Rays, CAT Scans, MRI's/NMR's/Special Studies? If so, please list the reason and date: _____

Have you ever experienced any major traumas or injuries (mentally or physically in nature)? If so, please list with dates: _____

Do, or have, any of your family members suffered from: (Please list relationship to you)

Alcoholism	Arteriosclerosis	Heart Disease
Allergies (list)	Asthma	High Blood Pressure
_____	Cancer	Seizures
_____	Diabetes	Stroke
_____	Mental Illness	

Which of the following is part of your lifestyle? How frequently do you engage in it? (always, frequently, sometimes, almost never, never)

Alcohol	Nicotine	Exercise
Coffee	Recreational Drug Use	Excessive Sugar

Do you usually eat three meals a day? _____ Do you follow any particular diet? Y N If so, please explain: _____

Please indicate your typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What foods and/or tastes do you crave the most? _____

Do you practice any forms of relaxation and/meditation techniques? If so, please list:

Daily Exercise: _____

Interests and hobbies: _____

Education: _____

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

REVIEW OF SYSTEMS:10 QUESTIONS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue. Please circle any symptoms you experience now and underline any that you have experienced in the past. If a symptom is not listed you can write it in.

Temperature

You have a tendency to feel:

Hot Cold Neutral

If hot or cold, what part/part's of the body, and at what times during the day or night?

Perspiration

Do you tend to sweat easily? Y N If yes, what part/part's of your body, and what times during the day or night? If no, is it even hard for you to sweat during exercise? Y N

Head and Face

Headaches (Where?) Dizziness Memory Loss Lack of Concentration

Other:

Heart and Chest

High Blood Pressure Low Blood Pressure Chest Pain Chest Tightness

Difficulty Lying Down Heart Disease Stroke Heart Murmurs

Rheumatic Fever Palpitations/Fluttering Pacemaker Arteriosclerosis

High Cholesterol Other:

Circulation

Easy Bruising Pain in Legs Swelling of Ankles Deep Vein Thrombosis

Varicose Veins Reynaud's Syndrome Discoloration on Skin

Cold Limbs/Hands/Feet Easy Bleeding Other:

Respiration

Pneumonia Frequent Common Colds Emphysema Pleurisy Asthma

Tuberculosis Difficulty Inhaling Difficulty Exhaling Pain Cough

Congestion Shortness of Breath Blood Phlegm (What color? How much & how often?) Other:

Skin

Acne Dryness Itchiness Flaking Moles that Change Lumps

Excessive Sweating Night Sweating Rarely Sweat Rashes

Eczema/Hives Warts Other:

Eye

Blurry Vision Eyelid Twitching Floaters Pain/Tension Glaucoma

Glasses/Contacts Tearing/Dryness Other:

Ear

Impaired Hearing Ear Wax Ear Aches Ear

Ringing Other:

Nose

Frequent Colds Sinus Trouble Bleeding Hayfever

Phlegm/Discharge (What color? How much & how often?) Other:

Throat

Sore Throat Hoarseness Difficulty Swallowing Dryness

Swollen Glands Never Thirsty Always Thirsty Other:

Do you prefer to drink hot or cold drinks? Does your preference change based on the time of day or night?

Mouth

Dental Problems Gum Problems Teeth Grinding/TMJ Unusual Tastes

Other:

Muskuloskeletal

Neck/Shoulder Pain Up/mid/low Back Pain Arm Pain Leg Pain

Muscle Spasms/Cramps Joint Pain? _____

Other areas of Pain or Discomfort: (Please Describe)

Neurological

Nervousness/Anxiety Tremors Numbness or Tingling

Lack of Coordination/Balance Nerve Pain Paralysis Seizures

Epilepsy Parkinson's Disease Multiple Sclerosis Other:

Gastrointestinal

Excessive Appetite Low Appetite Hungry but Don't Feel like Eating Gas/Bloating

Passing Gas Belching Heartburn Stomach/Abdominal Pain

Epigastric Pain Nausea Vomiting Diarrhea/Loose Stools

Constipation Undigested Food in Stool Mucous in Stool Rectal Bleeding

The Color of my Stool Tends to Be: Light brown Dark brown Pale Green Other:

The Odor of my Stool tends to Be: Mild Intense Other:

Colon Problems Chron's Disease Diverticulitis Ulcer Hemorrhoids

Appendicitis Intestinal Parasites Gout Gallbladder/Liver Disease Other:

Endocrine

Hormone Imbalance Hypoglycemic Hypo/HyperThyroid Diabetes Mellitus

Diabetes Insipidus Other:

Genito-Urinary

Urination: Frequent Difficult Painful Color? _____

Cloudiness Blood Urinary Tract Infections Venereal Disease Other:

Sleep

Insomnia Drowsiness Excessive Dreaming Nightmares Waking Easily

Hard to Fall Asleep Easy to Fall Asleep Narcolepsy Sleep Walking

Other:

How many hours a night do you sleep?

Energy and Immunity

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue

Allergies High Energy Low Energy Other:

On a scale of 1-10 (10 being the most amount of energy), where would you rate your energy level?

Emotional

Mood Swings Nervousness/Anxiety Mental Tension

Depression/Sadness Grief Irritability Anger Other:

On the scale of 1-10 (10 being the highest amount of stress), how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (i.e., more headaches, stomach pain, etc.)

Misc.

Bleeding Disorders Weight Loss Weight Gain

Are there any other health concerns you would like to address or that we may have missed in our questioning? If so, please explain

Is there anything else we should know?

WOMEN ONLY

Are you, or could you be pregnant? _____ If so, how far along? _____

Number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Any difficulties in conceiving? Y N

What form of birth control do you use? _____

Do you have regular PAP smears? _____ How Often? _____ Any history of any abnormalities with PAP's? _____

Age of first menses _____ Age of menopause, if applicable _____

Do you bleed between periods? _____ Do you bleed after intercourse? _____

Do you experience any pain during or after intercourse? _____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

Do you have any vaginal discharge? (This includes ovulation) Y N If so, how often?

How much? _____ What color? _____

Do you experience nipple discharge? _____ Breast Lumps? _____
Are your periods uncomfortable or painful, either emotionally or physically? _____

Are your periods?

Short (less than 28 days) _____ Long (28+ days) _____ Varied _____ Regular _____

Painful? If so, Before _____ During _____ After _____ Where? _____

Do you bleed heavily? _____ Lightly? _____ Very little? _____

Do you have clots? _____ Early in the cycle _____ or Throughout? _____

Relative to the blood that comes from a wound, is your menstrual blood: The same color _____ More
pale _____ Purple _____ More Red _____ More Brown _____

How many days do you bleed? _____

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese
Medicine, they are neither good nor bad. They are, however, an important diagnostic tool. Please answer
honestly.)

Irritability _____ Depression _____ Crying _____ Rage _____ Nausea _____

Cravings, and if so for what? _____ Breast Tenderness _____

Any other symptoms around the time of your period? _____

_____ Are you
experiencing any low or high sexual desires? _____ Do you have any concerns surrounding this?

MEN ONLY

Do you experience any of the following:

Reduced Libido _____ Excessive Libido _____ Impotence _____

Urinary Frequency _____ Premature Ejaculation _____ Discharge _____

Genital/ Testicular pain or Swelling _____

Prostate Problems? _____

Any other concerns? _____

I have provided correct and complete information to the best of my knowledge.

Patient's or Guardian's signature

Date