Chinese Medical Clinic

**New Patient Health History**

# *Our mission is to provide complete and successful holistic health care and preventative medicine. This is only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this CONFIDENTIAL questionnaire as thoroughly as possible. If you have any questions, please ask. Thank you.*

### Personal Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before? Yes No

## **Physician Information**

Name of Primary Doctor or Specialist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Medical Information

Sex: M F Height\_\_\_\_\_\_\_ Weight: Current\_\_\_\_\_\_\_ Past Maximum\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_\_

Please identify the health concerns for which you are seeking treatment in order of importance:

a.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did this start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did this start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did this start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have these conditions affected your daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other health problems you now have, and when they started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What related lab tests/X-rays/MRIs have been conducted (include dates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

 Your Approx. Your Approx.

Illness You Relative Date Illness You Relative Date

Cancer \_\_\_ \_\_\_ \_\_\_\_\_\_ Diabetes \_\_\_ \_\_\_ \_\_\_\_\_\_

Hepatitis \_\_\_ \_\_\_ \_\_\_\_\_\_ Heart Disease \_\_\_ \_\_\_ \_\_\_\_\_\_

High Blood Pressure \_\_\_ \_\_\_ \_\_\_\_\_\_ Kidney Disease \_\_\_ \_\_\_ \_\_\_\_\_\_

Stroke \_\_\_ \_\_\_ \_\_\_\_\_\_ Rheumatic Fever \_\_\_ \_\_\_ \_\_\_\_\_\_

Emotional Disorders \_\_\_ \_\_\_ \_\_\_\_\_\_ Tuberculosis \_\_\_ \_\_\_ \_\_\_\_\_\_

Infectious Diseases \_\_\_ \_\_\_ \_\_\_\_\_\_

Sexually Transmitted Diseases: \_\_Gonorrhea \_\_Syphilis \_\_AIDS \_\_HPV \_\_Chlamydia \_\_Herpes Date\_\_\_\_

List any medications and supplements you are currently taking(Continue on back if necessary):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medicine/Supplement | Dosage | Reason | How long? | Prescribed by | Date of last checkup? |
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List any accidents, surgeries or hospitalizations (Include date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often did you take antibiotics as a child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often have you take antibiotics as a teen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often have you take antibiotics as an adult?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Survey**

The following is a list of symptoms that you may or may not ever experience. Please check those you often experience.

\_\_lack of appetite

\_\_excessive appetite

\_\_loose stool or diarrhea

\_\_indigestion/gas

\_\_vomiting

\_\_belching/burping

\_\_heartburn

\_\_fullness in the stomach

\_\_chronic yeast infections

\_\_ obsessive in work/relationships

\_\_sleeping difficulties

\_\_heart palpitations

\_\_cold hands and feet

\_\_nightmares

\_\_mentally restless

\_\_angina pains

\_\_abdominal pain

\_\_chest pain

\_\_headaches

\_\_pain or cold in the genital area

\_\_nasal problems

\_\_allergies

\_\_cough

\_\_bronchitis

\_\_shortness of breath

\_\_decreased sense of smell

\_\_skin problems

\_\_claustrophobia

\_\_constipation

\_\_colitis/diverticulitis

\_\_hemorrhoids

\_\_recent antibiotic use

\_\_eye problems

\_\_jaundice

\_\_difficulty digesting oily foods

\_\_gallstones

\_\_light colored stool

\_\_soft or brittle nails

\_\_easily angered/agitated

\_\_difficulty in making decisions

\_\_spasms/muscle twitch

\_\_low back pain

\_\_knee problems

\_\_poor hearing

\_\_ear ringing

\_\_kidney stones

\_\_decreased sex drive

\_\_hair loss

\_\_urinary problems

\_\_fatigue

\_\_edema

\_\_blood in stool

\_\_black tarry stool

\_\_easily bruised

\_\_asthma

\_\_catch colds easily

\_\_dizziness

\_\_fainting

\_\_sudden weight loss

### Nutritional Status

What sort of diet do you have? (check one) Standard American Weight loss type

 Fast/Quick Prep Diet Vegetarian Vegan Low Fat Low Carbs

 Muscle Building Diet Balanced Food Groups Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies or food sensitivities that you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any food cravings that you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and symptom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use and frequency of: tobacco \_\_\_\_\_\_ alcohol \_\_\_\_\_\_\_\_ coffee\_\_\_\_\_\_ soda\_\_\_\_\_\_\_ fast food\_\_\_\_\_\_\_\_\_ foods with refined sugar\_\_\_\_\_\_\_\_\_ dairy products\_\_\_\_\_\_\_\_\_bread or wheat products\_\_\_\_\_\_\_\_\_\_\_

Water intake/day\_\_\_\_\_glasses

### Intestinal Status

How often do you have a bowel movement?

 1-3 times/day more than 3 times/day 2-3 times/week 1 time/week or less

Please describe your bowel movement consistency:

 soft and well formed often float difficult to pass diarrhea

 thin, long or narrow small and hard loose but not watery alternating between hard and loose

Please describe your bowel movement color:

 medium brown very dark or black greenish blood is visible

 variable yellow or light brown chalky colored greasy, shiny

### Lifestyle

Have you ever lived or traveled outside of the United States? If so, when and where?

Have you or your family recently experienced any major life changes? If so, please describe:

Have you experienced any major losses in life? If so, please describe:

Have you been exposed to any chemicals or toxic metals?

Are you active? (check one) Sedentary Job w/o exercise Sedentary Job w/ Much Exercise

 Sedentary Job w/ Some Exercise Active Job w/o Extra Exercise Active Job w/ Exercise

What type of exercise do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you characterize your life in terms of stress?: (check one)

 High Stress Much Stress Fairly Stressed Mild Stress Periodic Stress Not Stressed

Do you experience any of the following moods often? (check all that apply)

 Depression Anxiety Insecurity Anger Irritability Phobias Nervousness

 Mood Swings Sadness Short Tempered Obsessive Thinking Isolated Hopelessness

In which of the following areas of life are you satisfied?

 Your work Your relationships Your family Your spiritual life Your health Your security

### For Women

Age of first menses\_\_\_\_\_\_\_\_ Age of menopause\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes No # of pregnancies\_\_\_\_\_ # of live births\_\_\_ # of miscarriages\_\_\_\_\_

Number of days between periods\_\_\_\_\_ Date of last gynecological exam\_\_\_\_\_\_\_ Pap smear\_\_\_\_\_\_\_\_\_\_\_

Number of days of flow\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone density scan\_\_\_\_\_\_\_\_\_\_\_

Color of flow\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clots? Yes No Color\_\_\_\_\_\_\_

Heavy flow?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking birth control pills? Yes No

Please list dates of previous birth control pill use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts

 PID Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Pain: Lower Abdomen Lower Back Thighs Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of Pain (Indicate before, during of after menses) Other symptoms related to menses

Cramping\_\_\_\_\_\_\_\_\_\_\_\_ Stabbing\_\_\_\_\_\_\_\_\_\_ \_\_Discharge \_\_Vaginal Dryness \_\_Headache

Burning\_\_\_\_\_\_\_\_\_\_\_\_\_ Aching\_\_\_\_\_\_\_\_\_\_\_ \_\_Nausea \_\_Constipation \_\_Diarrhea

Dull\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bloating\_\_\_\_\_\_\_\_\_\_ \_\_Swollen Breasts \_\_Mood Swings \_\_Big Appetite

Consistent\_\_\_\_\_\_\_\_\_\_\_ Intermittent\_\_\_\_\_\_\_ \_\_Poor Appetite \_\_Hot Flashes \_\_Night sweats

Bearing down sensation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Increased Libido \_\_Decreased Libido \_\_Insomnia

### For Men

Date of last prostate check up\_\_\_\_\_\_\_ PSA results\_\_\_\_\_\_\_\_\_ Manual prostrate exam results\_\_\_\_\_\_\_\_

Lab results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of urination: daytime\_\_\_\_\_\_\_\_\_\_\_ nighttime\_\_\_\_\_\_\_\_\_\_\_ Color of urine\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms:

\_\_Prostrate problems \_\_Delayed stream \_\_Dribbling \_\_Incontinence \_\_Retention of Urine

\_\_Rectal Dysfunction \_\_Increased libido \_\_Decreased libido \_\_Premature ejaculation \_\_Impotence

\_\_Back pain \_\_Groin pain \_\_Testicular pain \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_