Medical History Questionnaire

This is an outline for recording your medical history. **This information as well as the results of any Physical examinations, conversations, special procedures and laboratory test is confidential. Reports will be furnished only with your request and permission.**

You are asked to fill out this record and bring it with you to your first appointment. Please complete each page. Remember to take you time. It will help us help you.

Many of out patients are chemically sensitive. Please avoid the use of fragrances or perfumes when visiting out office. Thank you.

East-West Acupuncture Clinic
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www.east-westacupuncture.com

Your appointment will be

Date____
Time____

There is a large demand for appointments and specific appointment times and limited number of spaces available. We do our best to try and accommodate patient's needs. We also are very careful about out schedule so that patients do not have to wait.

Please read and sign below:
"I understand that appointment times are reserved especially for me. 24 hours notice of any changes is appreciated. Full fee will be charged for missed appointments and half fee for same day cancellations. Unless other arrangements have been made, I understand the payment is due at the end of each visit."

Signed____ Date________________________

Name____
(Last) (First) (Middle)

Address____
(City) (State) (Zip Code)

Home Telephone______________________ Work Telephone__________________ Cell________________________

E-Mail____

Age_________ Birthday______________ Birth Place____

Marital Status (Circle One) Single Married Widow Divorced Separated

Occupation________________________________ Employer____

Name of Spouse or (Parent, if Patient is a minor) ____

Spouse/Parent Occupation____________________________ Employer_______________________________________

Name of person other than member of household to notify in case of emergency

Name___________________________________ Relationship to Patient_____________________________________

Do you have health and accident insurance? Yes No

Insurance Company____________________________ Persons Insured______________________________________

Group #_______________________________________ Insured Date of Birth__________________________________

Do you have an Active Worker's Comp Claim? Yes No

Do you have an Active or Pending Auto or Accident Claim? Yes No

Who referred you to our office? ____

Have you had acupuncture before? Yes No If Yes, Where and When ________________________________
____
____

Present Physician(s) ____
____
____
____

Chief Complaints (Reason for your visit)

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____
____
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____
____
____
____
____

Are you Aware of any factors that have directly or indirectly contributed to these problems? Yes No

If Yes, Please List____
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____
____
____

To the best of your knowledge, have any of your close relatives (e.g., Father, Mother, Sister, Brother or Grandparent) suffered from any of the following? (Circle Yes or No)

Condition			Condition		
Diabetes	Y	N	Stomach Disease	Y	N
Tuberculosis	Y	N	Leukemia	Y	N
Cancer	Y	N	Anemia	Y	N
Nephritis	Y	N	Arthritis	Y	N
Bleeding Tendency	Y	N	Rheumatic Fever	Y	N
Heart Disease	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Hay Fever	Y	N
Gout	Y	N	Other Allergies	Y	N
Migraine	Y	N	Obesity	Y	N
Gallbladder Disease	Y	N	Fibromyalgia	Y	N

Injuries Include Broken Bones, Sports Injuries, Sprains, Falls, Etc.
____
____
____
____
____

Operations (List any Operations you have had & Dates if possible) ______________________________
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____
____
____
____

Foreign Residence or Travel (List Places and Dates outside the U.S.____
____
____
____
____

Past Occupations____
____
____

Occupational Hazards (List any exposure to toxic chemicals, dusts, paints, sprays, etc.) ___________________
____
____
____
____

Medications and Vitamins

Do you take Sleeping Pills? Y N
Do you take Any Medication/s for Anxiety or Depression? Y N
Do you take Vitamins and/or Minerals? Y N
Do you take Herbs? Y N
Do you take Prescription Medications? Y N
Do you take Over the Counter Medications? Y N
If answered yes to any of the above questions, Please List______________________________________
____
____
____
____
____

Habits

How many cups of Coffee do you drink each day? ____
How many cups of Tea do you drink each day? ____
How many glasses of water do you drink each day? ____
How many alcoholic drinks do you have each day? ____
Do you like to use extra salt on your food? ____
Do you like sour tasting foods? ____
How many Cigarettes or Cigars do you smoke daily? ____
What type of Beverage do you drink daily? ____
How many hours do you sleep on the average? ____
When did you last take a week or more vacation? ____
Do you Exercise regularly? Y N type? _______________ frequency? ___________________
Do you participate in amateur or professional sports? ____
What do you do with your spare time? ____
____
____

Body Weight
What is the most you have ever weighed? ____
What is the present Weight? ____
What is your average Weight? ____

Height
What is your Height? ____

General Health
Are you considered to be a healthy person? ____

Allergic Disorders

Hay Fever	Y	N
Hives	Y	N
Asthma	Y	N
Eczema	Y	N

Season of the year bothered? ____
Cause, if known? ____
Allergies to Shellfish, other fish or any other foods? ____
Allergies to Animals, Dust, Pollens, Molds, Etc.?____
Chemical Sensitivities? ____
Are you Allergic to or Affected adversely by any Medicines or Drugs? ____
If Yes to any of the above, Explain ____

Acute Contagious Diseases (circle Y or N and give approximate age)

Chicken Pox	Y	N	Scarlet Fever	Y	N
Measles	Y	N	Whooping Cough	Y	N
German Measles	Y	N	Diphtheria	Y	N
Smallpox	Y	N	Mumps	Y	N
Hepatitis	Y	N	HIV/ AIDS	Y	N
Influenza	Y	N	Rheumatic Fever	Y	N
Tuberculosis	Y	N	Polio	Y	N
Meningitis	Y	N	Encephalitis	Y	N
Malaria	Y	N			

Other____
If yes to any of the above, Explain____

Other Diseases

Diabetes	Y	N	Gallbladder Disease	Y	N
High Blood Pressure	Y	N	Low Blood Pressure	Y	N
Liver Disease	Y	N	Chronic Fatigue	Y	N
Cancer/Ulcers	Y	N	Fibromyalgia	Y	N
Lung Disease	Y	N	Kidney Disease	Y	N
Heart Disease	Y	N	Other ______________________		

If Yes to any of the above, Explain____

Review of Body Systems

Skin, Hair & Nails

Have you ever had skin troubles such as itching, discoloration, boils, acne or athlete's foot? Y N

Is your Skin Oily___ Dry___ Normal___

Is your Hair Oily___ Dry___ Normal___

Do you perspire excessively? Y N

Is your skin sensitive to sunlight? Y N

Do you use hair dyes, sprays or rinses? Y N

Do you have any problems with hair falling out? Y N

If Yes to any of the above questions, Explain____

Head

Do you have frequent headaches? Y N

Migraines? Y N

Location of headaches? ____

Frequency? ____

Do you have dizziness or lightheadedness? Y N

Is there nausea or vomiting associated with your headaches? Y N

Do your headaches come at a specific time of day or month? Y N

If Yes to any of the above, Explain____

Eyes

Do you have difficulty reading? Y N

Do you wear glasses? Y N

Do you have pain in your eyes? Y N

Do you have cataracts? Y N

Do you have Glaucoma? Y N

Do you have pain in your eyes while reading? Y N

Do you have problems seeing distance? Y N

Do you see double? Y N

If Yes to any of the above, Expain____

Ears

Do you have loss of hearing? Y N

Do your ears ring? Y N

Is there a "buzzing" in your ears? Y N

Do you have Vertigo? Y N

If Yes to any of the above, Expain____

Nose

Do you have nasal allergies? Y N

Do you have frequent colds? Y N

Do you have frequent nose bleeds? Y N

Do you have difficulty smelling? Y N

Do you have discharge that drips down the back of your throat? Y N

If yes to any of the above, Explain____

Throat

Do you have frequent sore throats?	Y	N
Do you have a chronic cough?	Y	N
Have you had your tonsils removed?	Y	N

If yes to any of the above, Explain____

Mouth

Do you have frequent canker sores?	Y	N
Do you have difficulty chewing?	Y	N
Do you have TMJ problems?	Y	N
Do you have difficulty swallowing?	Y	N
Do you have trouble with your teeth?	Y	N
Do you have trouble with your gums?	Y	N

If yes to any of the above, Explain____

Taste

Spicy	Most___	Often___	Some___	Never___
Salty	Most___	Often___	Some___	Never___
Sour	Most___	Often___	Some___	Never___
Bitter	Most___	Often___	Some___	Never___
Sweet	Most___	Often___	Some___	Never___

Other____

If yes to any of the above, Explain____

Neck

Do you have neck pain?	Y	N
Do you have stiff neck?	Y	N
Have you had any injury to your neck?	Y	N
Do you have thyroid problems?	Y	N
Do you take thyroid pills?	Y	N

If yes to any of the above, Explain____

Heart

Have heart trouble?	Y	N
Have pressure Sensation in the chest?	Y	N
Are you short of breath?	Y	N
Have you had a heart attack?	Y	N
Does your heart skip beats?	Y	N
Do you have ankle swelling?	Y	N
Do you have to stop and rest when climbing stairs?	Y	N
Do you have heart mummer?	Y	N
Have you had an EKG?	Y	N
Do you have a pace maker?	Y	N

If yes to any of the above, Explain____

Lungs (Do you now or have you ever had problems with?)

Pneumonia	Y	N	Frequent Cough	Y	N
Bronchitis	Y	N	Asthma	Y	N
Respiratory Infection	Y	N	Chest Pain	Y	N
Excessive phlegm	Y	N	Wheezing	Y	N
Do you smoke?	Y	N	Other? ______________________		

If yes to any of the above, Explain____

Gastrointestinal

Nausea or vomiting?	Y	N			
Do you eat 3 meals a day?	Y	N	Abdominal pain?	Y	N
Do you have a good appetite?	Y	N	Constipation?	Y	N
Do you have pain with swallowing?	Y	N	Diarrhea?	Y	N
Heart burn?	Y	N	A well balanced diet?	Y	N
Snacks between meals?	Y	N	Do you take antacid?	Y	N
A sour stomach?	Y	N	Candida Albicans?	Y	N
Drink ice cold liquids?	Y	N	How often do you eat ice cream a week?________		

If stomach pain or yes to any of the above, Explain____

____

Liver, Gallbladder & Pancreas (have you ever had?)

Yellow jaundice	Y	N	Hepatitis	Y	N
Gallbladder disease	Y	N	Trouble with your Pancreas	Y	N
Cirrhosis	Y	N	Other?___________________	Y	N

If yes to any of the above, Explain____

Spleen & Blood (have you ever had?)

An enlarged Spleen?	Y	N	Enlargement of Lymph Nodes?	Y	N
A tendency to bleed?	Y	N	A tendency to bruise easily?	Y	N
Do you take aspirin/blood thinners?	Y	N			

If yes to any of the above, Explain____

Genito-Urinary (have you ever had?)

A bladder infection?	Y	N	Albumin (protein) in urine?	Y	N
A kidney infection?	Y	N	Blood in the urine?	Y	N
A kidney stone?	Y	N	Sugar in the urine?	Y	N

How many times a night do you get up to pass urine?____

If yes to any of the above, Explain____

Bones, Joints & Extremities (do you have?)

Bursitis	Y	N	Arthritis	Y	N
Backache	Y	N	Foot Pain	Y	N
Joint swelling	Y	N	Rheumatism	Y	N
Any numbness in legs or feet?	Y	N	Joint Pain	Y	N
Any numbness in arms or hands?	Y	N	Numbness that runs down the leg?	Y	N
Surgery for your Neck or Back?	Y	N			

If yes to any of the above, Explain____

Neuromuscular (have you had?)

Leg cramps at night?	Y	N	Tremor in hands or feet?	Y	N
A Stroke?	Y	N	Periods of losing consciousness?	Y	N
A herniated disc?	Y	N	Shooting pains in arms or legs?	Y	N
Meningitis?	Y	N	Sciatica?	Y	N
Polio?	Y	N	Neuralgia or Neuritis?	Y	N

If yes to any of the above, Explain____

____

Do you have?

Difficulty thinking?	Y	N	A good memory for the past events?	Y	N
Any muscle weakness?	Y	N	Any difficulty climbing stairs?	Y	N
Depression?	Y	N	Fear of strange people or place?	Y	N
Anxiety?	Y	N	Losses of memory?	Y	N

If yes to any of the above, Explain____

____

Do You?

Cry Frequently?	Y	N	Easily becomes fearful?	Y	N
Often get angry?	Y	N	Mostly feels joy & happiness?	Y	N
Worry or think a lot?	Y	N	Feel that life is hopeless?	Y	N

If yes to any of the above, Explain____

____

Are you?

Constantly fatigue & tired?	Y	N	Always low on energy?	Y	N
Considered shy or sensitive?	Y	N	Often nervous or Jittery?	Y	N

If yes to any of the above, Explain____

____

MALE PATIENTS (Have you ever?)

Had trouble with the Prostate? Y N
Enlargement of Testicles? Y N
Ever had Erection problems? Y N
Sexually Transmitted Disease? Y N
Other issues/problems/concerns? Y N
If yes to any of the above, Explain____
____

FEMALE PATIENTS

Age when you begun to Menstruate?_______
Length of periods?________________
Interval between periods?________________
There is/was pain with period?_____________
Last Menstrual Period?__________________

Do you have or have you ever had?

Frequent cold hands and feet? Y N
Sexually Transmitted Disease? Y N
Clotting with periods? Y N
Endometriosis Y N
Hot Flashes? Y N
A Caesarean Section? Y N
Problems getting pregnant/carrying pregnancy? Y N
Stress during Pregnancy? Y N
Bleeding between periods? Y N
Birth control pills? Y N
Miscarriage? Y N
How many times have you been pregnant?_______
How many children do you have?______________
If yes to any of the above, Explain____
____

ALL PATIENTS

Do you currently get chiropractic or osteopathic treatments? Y N
If yes to any of the above, Explain____

Other Issues

Are there any other problems or issues that you would like to discuss? Y N
If yes to any of the above, Explain____
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