Medical Questionnaire

Acupuncture Plus-------All information is completely confidential

Your Past Medical History
Check any of the following conditions that you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

AIDS/HIV ___ Alcoholism ___Allergies ___ Appendicitis ___ Arteriosclerosis ___ Asthma ___ Birth Trauma (your own birth) Cancer ___ Chicken Pox ___ Diabetes ___ Emphysema ___ Epilepsy ___ Goiter ___ Gout ___ Heart Disease ___ Hepatitis ___ Herpes ___ High Blood Pressure ___ Measles ___Multiple Sclerosis ___ Mumps ___ Pacemaker ___ Pleurisy ___ Pneumonia ___ Polio ___ Rheumatic fever ___ Scarlet fever ___ Seizures ___ Stroke ___ Thyroid disorders ___ Tuberculosis ___ Typhoid fever ___ Ulcers ___ Venereal disease ___ Whooping Cough ___ Other (specify)

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List any surgeries you have had:

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List any major trauma you have had:

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General Symptoms

Poor appetite: ___ Heavy appetite ___ Strongly like cold drinks ___ Strongly like hot drinks ___ Recent weight gain/loss ___ Poor sleep ___ Heavy sleep ___ Dream-disturbed sleep ___ Fatigue ___ Lack of strength ___ Body heaviness ___ Cold hands/feet ___ Poor circulation ___ Shortness of breath ___ Fever ___ Chills ___ Night sweats ___ Sweat easily in the daytime ___ Muscle cramps ___ Vertigo or dizziness ___ Bleed or bruise easily ___ Peculiar taste in the mouth? describe _______________

Head, Eyes Ears, Nose, Throat

Glasses ___ Eye Strain___ Eye pain ___ Red eyes ___ Itchy eyes ___
Spots in eyes___ Poor vision ___
Blurred vision ___ Night blindness ___Glaucoma ___Cataracts ___Teeth problems ___ Grinding teeth___TMJ problems ___ Facial pain ___ Gum problems ___ Sores on lip or tongue ___ Dry mouth ___ Excessive saliva ___ Sinus problems ___
Excessive phlegm ___ Color of phlegm ___________________
Recurrent sore throats ___ Swollen glands ___ Lump in throat ___ Enlarged thyroid ___ Nose bleeds ___Ringing in ears ___ Poor hearing ___ Earaches ___ Headaches ___ Migraines ___ Concussion ___

Respiratory

Difficulty breathing when lying down ___ Shortness of breath ___ Tight chest ___ Asthma/wheezing ___Cough ___Wet or dry?_______ Thick or thin sputum?_________ Color of phlegm _________________

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Cardiovascular

High blood pressure ___ Blood clots ___ Low blood pressure ___ Fainting___ Chest Pain ___ Difficulty breathing ___ Tachycardia ___ Heart Palpitations ___ Phlebitis___ Irregular heart beat___

Gastrointestinal

Nausea___Vomiting___Acid regurgitation___Gas___Hiccup___Belching___ Bad breath___ Diarrhea___Constipation___Laxative use___Black stools___Bloody stools___Mucus in stools___Intestinal pain or cramping___Itchy anus___Burning anus___Rectal pain___Hemorrhoids___Anal fissures___

Musculoskeletal

Neck/shoulder pain___Muscle pain___Upper back pain___Low back pain___Joint pain___Rib pain___ Limited Range of Motion___Limited use___Other (describe)

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Neuropsychological

Seizures___Numbness___Tics___Poor memory___Depression___Anxiety___Irritability___Easily stressed___ Abuse Survivor___Considered/attempted suicide___Seeing a therapist___Other_________

Genitourinary

Pain on urination___Frequent urination___Urgent urination___Blood in urine___Unable to hold urine___Incomplete urination___Venereal disease___Bedwetting___Wake to urinate___Increased libido___Decreased libido___

Kidney stone___Other____

Gynecology

Age Menses Began___Length of cycle(e.g. every 28 days, every 30 days, every 14 days, etc.)____________________________

Duration of the flow (e.g. 3-7 days, etc.) ________Irregular periods___

Painful periods___PMS___ Vaginal discharge__Vaginal sores___

Vaginal odor___Clots___Breast lumps___# of Pregnancies___# of live births ________

Premature births___Age at menopause___Date of last PAP_______________________

Please attach any additional information you wish to explain, or additional copies of radiology or pathology tests.