**PATIENT HISTORY**

Name ________________________________ DOB __________ Sex (circle one): F / M / T

Home address ____________________________________ City ____________________________

State ___________________ Zip _______________ Cell phone ___________________________

Alternate contact number _______________________ Email _____________________________

Primary care physician and contact number ___________________________________________

Who referred you to our office? ______________________________________________________

Emergency contact name and number ___________________________________________________

Occupation ________________________ Have you had acupuncture before?__________________

When ________________ From whom __________________________________________________

**Please check the following applicable statements and provide further info if asked:**

_____ I have allergies to ____________________________________________________________

_____ I have a pacemaker _____ I take Coumadin/warfarin _____ I take lithium

_____ I drink caffeine Type ______________________ # of cups daily ________________

_____ I use tobacco Type _________________ # of cigarettes per day_____ # of yrs _____

_____ I drink alcohol Type __________________ # of drinks per week _______________

_____ I drink soda (regular or diet) Type _______________ # per week _______________

_____ I use recreational drugs Type _______________ # of times per week _____________

**Please list any medications and supplements you're currently taking:**

| Medicine | Dosage | Reason | How long | Date of last checkup |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Family history**: Please check the applicable illnesses below for you and any immediate blood relatives (parent, sibling, grandparent) and give an approximate date of onset:

| Illness | You | Relative | Date | Illness | You | Relative | Date |
|---|---|---|---|---|---|---|---|
| Cancer | ____ | __________ | ________ | Hepatitis | ____ | ____________ | ________ |
| Diabetes | ____ | __________ | ________ | TB | ____ | ____________ | ________ |
| Heart disease | ____ | __________ | ________ | Depression | ____ | ____________ | ________ |
| Hypertension | ____ | __________ | ________ | Seizures | ____ | ____________ | ________ |
| MRSA | ____ | __________ | ________ | HIV | ____ | ____________ | ________ |
| Rheumatic fever | ____ | _________ | _______ | | | | |

Other emotional disorders (bipolar, schizophrenia) ____ ____________ ________

What are you chief complaints (from most to least problematic)? ______________________________

______________________________________________________________________________

______________________________________________________________________________

What other forms of treatment have you sought? ________________________________________

______________________________________________________________________________

What kind of exercise do you do and how often? ________________________________________

______________________________________________________________________________

What are your goals in seeking acupuncture (fertility help, pain relief, stress management, etc.)?

1. ____________________________________________________________________________

2. ____________________________________________________________________________

3. ____________________________________________________________________________

List any food allergies/sensitivities (provide approx date of onset) ______________________________

______________________________________________________________________________

______________________________________________________________________________

List any injuries, accidents, surgeries or hospitalizations with approx. date ______________________

______________________________________________________________________________

______________________________________________________________________________

**How do you feel about the following areas of your life (check the appropriate blank)?**

| | Great | Good | Fair | Poor | Bad | Comments |
|---|---|---|---|---|---|---|
| Significant other | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Family | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Diet | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Sex | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Self | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Work | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Exercise | _____ | _____ | _____ | _____ | _____ | ________________________ |
| Spirituality | _____ | _____ | _____ | _____ | _____ | ________________________ |

**FOR WOMEN:**

Are you pregnant (y/n/maybe) __________ Date of last period ____________ Age at first period ______

Number of pregnancies _______ Number of live births ______ Number of abortions ________________

Number of miscarriages (please provide dates and gestational age) ______________________________

______________________________________________________________________________

Did you conceive naturally? ____________________ History of pre-term pregnancies or complications:

______________________________________________________________________________

Date of last gynecologic exam __________ Date of last PAP test ___________________________________

Date of last mammogram ______________ Date of last bone density scan __________________________

Date of last colonoscopy/fecal occult blood test __________________________________________

Date of last blood panel (glucose, cholesterol, blood count, etc.) ___________________________________

Note any negative/borderline test results ____________________________________________________

______________________________________________________________________________

Are your periods regular? __________________ Avg. length of cycle (Day 1 to Day 1) ________________

Days of flow _________ Color of blood flow ______________________ Are there clots? ______________

Heavy, light or average flow ____________________________ Is your period painful? _________________

Is the pain before, during or after__________________________________________________________

How long does pain last? ______________ Location of pain (abdomen, back, breasts, thighs or elsewhere) ________________________________________________________________________________________________

**Please circle any other symptoms/conditions related to your menses**: discharge, nausea/vomiting, swollen breasts, poor appetite, ravenous appetite, increased libido, decreased libido, vaginal dryness, constipation, loose stools, mood swings, hot flashes, headache, night sweats, insomnia, depression, PCOS, endometriosis, other ____________________________________________________________________________________

________________________________________________________________________________________________

Describe any pain or symptoms mid-cycle (around ovulation) ___________________________________________

Approximately what day of cycle do ovulation symptoms start ___________________________________________

How long do symptoms last? ____________________

History of yeast infections? ________________________________________________________________________________

History of UTI? ______________________________________________________________________________________________

History of sexually transmitted infections? ________________________________________________________________