JANET CHUNG ACUPUNCTURE & HERBAL MEDICINE

# PATIENT CONFIDENTIAL INFORMATION

Name: _____ Date: _____/_____/_____

Date of Birth _____/_____/_____ Place of Birth: _____
MM DD YY

Sex: Female / Male Marital Status: Single / Married / Divorced / Widowed

Address: _____
Street Apt #

_____
City State Zip

Cell / Home Phone: _____ Business Phone: _____

E-Mail Address: _____

Occupation: _____ Employer: _____

Emergency contact:_____
Name Relation

Emergency contact phone #: _____

**Insurance**

Company Name: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

How did you hear about us? _____

| First Name: | Last Name: | Date: |
|---|---|---|

**MEDICAL HISTORY QUESTIONNAIRE** (Page 1 of 3)
*Please complete the following as accurately as possible.*

**Medical History:**
What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking (Prescription, supplements, and any other over the counter medication)?

**Which, if any, of your blood relatives have had any of the following?**

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Substance abuse

**Social History:**

How many per week do you use of the following on average:

Coffee / Tea / Soft Drinks: _____ Alcohol: _____ _____

Cigarettes/ Cigars : _____ Other Substance : _____

How many days a week do you exercise on average? _____

Activity: _____ _____

Stress level: On a scale from 1-10 (10 being the most stressed), how would you rank your stress level? _____

**For Women: Menstrual History**

Age of your first period:_____ Vaginal discharge:_____ Last Pap smear _____

Length of cycle, day 1 to day 1_____ Length of flow (days):_____ Any history of an abnormal pap smear? Yes / No

Date of your last period:_____ Do you believe you are pregnant? Yes / No

Do you have any of the following menstruation related symptoms?

☐ Blood clots ☐ Cramps ☐ Nausea ☐ Breast Distention ☐ PMS
☐ Bleeding between periods ☐ Water retention ☐ Heavy vaginal discharge between periods

The flow is: ☐ Heavy ☐ Normal ☐ Light The color is: ☐ Dark red ☐ Purple ☐ Light brown ☐ Brown ☐ Normal

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| First Name: | Last Name: | Date: |
|---|---|---|
| | | |

## MEDICAL HISTORY QUESTIONNAIRE

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(please write the word "Past" next to those conditions which you have ONLY had in the past and which are no longer present)

HEAD AND NECK:
- Dizziness
- Fainting
- Neck Stiffness
- Enlarged lymph glands
- Headaches
- Other _____

EARS:
- Infection
- Ringing
- Decreased hearing
- Other _____

EYES:
- Blurred vision
- Visual changes
- Poor night vision
- Spots/Floaters ____
- Eye inflammation/ Styes
- Other _____

NOSE, THROAT & MOUTH:
- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Hoarseness
- Changes in taste
- Difficulty swallowing
- Changes in smell
- Oral ulcers/Canker sores
- Other ____

SKIN:
- Hives
- Rashes
- Eczema
- Psoriasis
- Seborrhea
- Night sweating
- Excess Sweating
- Dryness
- Bruise easily
- Changes in moles or lumps
- Other _____

NEUROLOGICAL:
- Numbness or tingling of limbs
- Seizures
- Tremors
- Pain
- Paralysis
- Epilepsy or Convulsions
- Other _____

INFECTION HISTORY:
- HIV/AIDS, or HIV risks: Self or partner
- TB: Self or household
- Hepatitis, or Hepatitis risk: Self or partner
- History of sexually transmitted diseases: Self or partner:
- Genital warts
- Herpes (oral)
- Herpes (genital)

RESPIRATORY:
- Chronic cough
- Coughing up blood
- Coughing up phlegm frequently
- Difficulty breathing
- Wheezing/Asthma
- Frequent Colds
- Emphysema
- Pneumonia repeatedly
- Other _____

CARDIOVASCULAR:
- Palpitations

Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Heart Disease
- Poor circulation
- Swelling of ankles
- Phlebitis
- Cold hands/feet
- Cardiac Pacemaker
- High blood pressure
- Stroke
- Other_____

GASTROINTESTINAL:
- Indigestion
- Nausea
- Stomach Pain
- Irritable Bowel Disease
- Colitis
- Crohn's Disease
- Pancreatitis
- Celiac Disease
- Recent change in bowel habits
- Diarrhea (stool/day)_____
- Constipation (stool / week)
- Dry, hard stool
- Soft, difficult, sticky stools

Irregular bowel movement
- Poorly-formed stools
- Poor appetite
- Excessive hunger
- Blood in stool or black stools
- Hemorroids
- Stool with pain or blood
- Gall bladder disorder
- Vomiting blood
- Peptic Ulcer
- Recent change in weight
- Food cravings
- Other _____

URINARY:
- Frequent urinary tract/bladder infections
- Weak urinary stream
- Recent change in bladder habits
- Kidney disease
- Frequent day urination
- Frequent night urination
- Others _____

MALE:
- Pain/itching of genitalia
- Genital lesions/discharge
- Impotence
- Premature ejaculation
- Prostate problems
- Infertility (e.g., abnormal sperm)
- Other: _____

FEMALE:
- Frequent vaginal infections
- Infertility
- Pain/itching of genitalia
- Genital lesions/discharge
- Pelvic inflammatory disease
- Abnormal Pap smear
- Irregular periods
- Emotional changes with menses
- Clots with menses
- Painful menstrual periods/cramps
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms (hot flashes, etc.)
- Breast lumps/cysts
- Breast swelling and/or pain
- Other _____

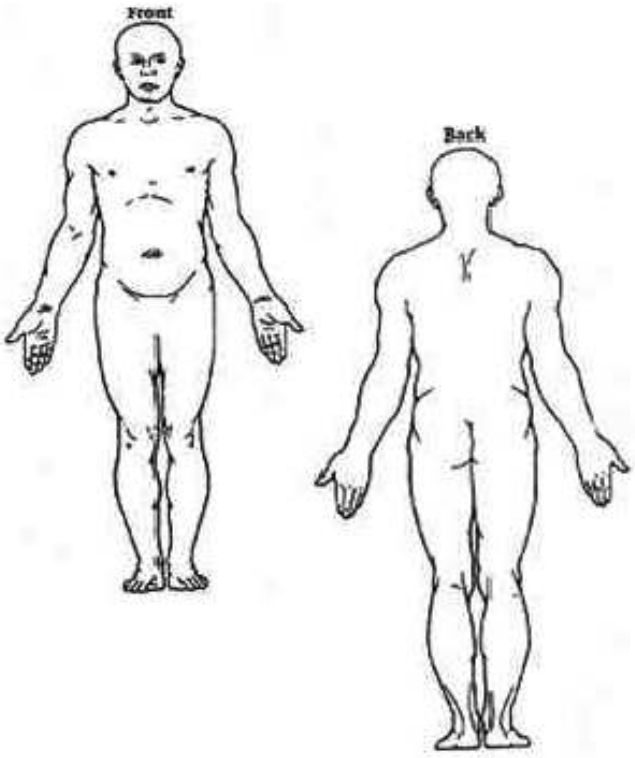
MUSCLES AND JOINTS:
- Joint disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache
- Back pain
- Fibromyalgia
- Other_____

GENERAL:
- Fatigue
- Thirst
- Aversion to Cold
- Insomnia
- Frequent dreams/ nightmares
- Depression
- Agitation
- Irritability
- Anxiety
- History of psychiatric treatment
- Poor memory
- Anemia or other blood disorder
- Lupus erythematosis
- Difficulty concentrating
- Sores that don't heal
- Unusual bleeding or discharge
- Jaundice
- Hernia
- Epstein Barr virus (EBV)
- Rheumatic Fever
- Diabetes Mellitus
- Thyroid Disorder
- Cancer

**Present Illness:**
What is your chief complaint?

Do you have any other major symptoms?

Mark with an X where you feel pain or discomfort.




On a scale from 1 to 10 (10 being most painful) how do you rate the pain?

Does the pain get worse at any part of the day?

Do you do anything to provide relief?

Is there anything that aggravates the pain?

Do you have a pacemaker?

When did this condition begin?

What treatment have you received already?

How is your symptoms affecting your daily life?

What would you like to achieve from getting your Traditional Chinese Medicine treatments?