

Medical History

Hidden Well Acupuncture Center

Name:	Primary phone:	Add'l phone:
Street:	Birthdate:	Age:
City:	Ht:	Wt.
State & Zip:	Occupation:	
Physician:	Referred by:	
Main Complaint/Problem		Onset:
Other Concurrent Therapies:		
Emergency Contact Name:		Phone:

Significant illnesses (circle and indicate dates):

- | | |
|---------------------|-----------------|
| Cancer | Rheumatic fever |
| Diabetes | Thyroid disease |
| High blood pressure | Seizures |
| Heart disease | Other |
| Hepatitis | |

List the following:

Surgeries:

Significant trauma (auto accidents, falls, etc.)

Births: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods, etc)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational stresses: (chemical, physical, psychological, etc.)

Exercise routine:

Other comments:

Average daily diet:

Morning:

Afternoon:

Evening:

Habits (circle all applicable): Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family History (circle all applicable): Diabetes Cancer High Blood Pressure Heart Disease Stroke

Seizures Allergies Alcoholism Other _____

Comments: _____

GENERAL

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Heavy sleep |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold back | <input type="checkbox"/> Cold abdomen |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden drop in energy at _____ (time) | | <input type="checkbox"/> Peculiar tastes/smells: _____ | |
| <input type="checkbox"/> Strong thirst (cold or hot preference) _____ | | <input type="checkbox"/> Bleed or bruise easily _____ (where) | |

Comments:

SKIN AND HAIR

- | | | | |
|--|--------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Purpura | <input type="checkbox"/> Other | |

Comments:

HEAD, EYS, NOSE, AND THROAT

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Copious saliva |

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Recurrent sore throats | |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Headaches (where/when) | | |
| <input type="checkbox"/> Other head/neck problems | | | |

Comments:

CARDIOVASCULAR

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other |

Comments:

RESPIRATORY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Difficulty breathing lying down | |
| <input type="checkbox"/> Production of phlegm – what color? | | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other lung problems |

Comments:

GASTROINTESTINAL

- | | | | |
|---|--|--|----------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | Bowel movement |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | Frequency: |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | Color |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Sensitive abdomen | Odor |
| <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Laxative use: times/week: | type: | Texture/form |

Comments:

GENITO-URINARY

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Urination pain | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Wake to urinate: how often? | time? | <input type="checkbox"/> Other G/U problems | |

Comments:

PREGNANCY AND GYNECOLOGY

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Number of pregnancies: | <input type="checkbox"/> Number births | <input type="checkbox"/> Premature births | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Age of first menses | <input type="checkbox"/> Days between periods: | <input type="checkbox"/> Duration | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Flow (describe) | <input type="checkbox"/> Clots | <input type="checkbox"/> Date of last PAP | <input type="checkbox"/> Date of last menses |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Birth control: (type and duration) | | <input type="checkbox"/> Changes in body/psyche during menstruation | |

Comments:

MUSCULOSKELETAL

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Back pain (where) | <input type="checkbox"/> Joint pain (where) |
| <input type="checkbox"/> Other joint problems | | | |

Comments:

NEUROPSYCHOLOGICAL

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Treated for emotional problems (when) | | <input type="checkbox"/> Considered/attempted suicide | |
| <input type="checkbox"/> Other neurological or psychological problems: | | | |

Comments: