General Patient Information

Date: _____________ Name: ____

Address: ____

City: ___________________________________ State: ___________________________ Zip: ____________________

E-mail Address: ____ Home/Cell Phone: _________________________

Referred by: ____

Date of Birth: _______________ Age: _______ Place of Birth: ____

Height: ___________ Weight: ___________ Gender: ❑ Male ❑ Female ❑ Transgender

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed

Occupation: ____

Guardian (if under 18): ____

Address (if different from patient): ____

Emergency Contact: __________________________ Relationship: _________________ Phone: ________________

Current Condition

What is the primary reason for your visit today? ____

____

How long have you had this condition? ____

Have you experienced this before? ____

What seemed to be the initial cause? ____

Have you seen a physician or other Western medical professional? ____

What therapies have you tried? ____

What other therapies are you currently receiving? ____

____

Patient History

Please list any known allergies – (ex. Latex, metal, pharmaceuticals, food, environmental):

____

____

Prescription drugs, over-the-counter medications, vitamins/herbs you are currently taking:	For what condition and dosage:
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

If you have ever been hospitalized for any serious medical illness or operation, list the year and procedure:

____

____

Physician's Name: ______________________________ Phone Number: ________________________

Date of last physical examination: __________________

Personal Lifestyle Habits (how much/how often)

❑ Cigarettes (packs): ________ ❑ Coffee/Tea (cups): ________ ❑ Alcohol (drinks): ________

Marijuana/Recreational drugs: ____

Women – OB/GYN History

Are you pregnant: ❑ Yes ❑ No If yes, how far along: ______________________________

# of pregnancies: _____ # of live births: _____ # of abortions: _____ # of miscarriages: _____

Date of last gynecologic exam: ___________ Pap Smear results: ______________________

Age of 1st period (menarche): _______ Age of last period (menopause): _______

When did your last period start? __________ What day of your cycle are you on today? _____

Please list any symptoms experienced with menstruation (ex. Cramps, bloating, etc.): ___________________

____

Have you been diagnosed with:

❑ Ovarian cysts ❑ PID ❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis

Men

Please check all that apply to you within the last 3 months:

❑ testicular pain	❑ painful erections	❑ incontinence
❑ history of STD	❑ erectile dysfunction	❑ retention of urine
❑ hernia	❑ impotence	❑ delayed stream
❑ prostate problems	❑ difficult ejaculation	❑ post void dribbling
❑ increased libido	❑ discharge from penis	❑ decreased force of urine stream
❑ decreased libido	❑ injury to reproductive organs	❑ currently sexually active
❑ cold feeling in genitals		

Please check all that apply:

General
- ❑ Insomnia
- ❑ dreams/nightmares
- ❑ Irritability
- ❑ Depression
- ❑ Mood swings
- ❑ Fatigue
- ❑ Poor memory
- ❑ Recent weight loss/gain
- ❑ Cold hands & feet
- ❑ Chills
- ❑ Hot flashes
- ❑ Anxiety

Head & Neck
- ❑ Headaches
- ❑ Migraines
- ❑ Stiff neck
- ❑ Dizziness
- ❑ Fainting
- ❑ Swollen glands

Ears
- ❑ Ringing
- ❑ Hearing loss
- ❑ Infections
- ❑ Hearing aids
- ❑ Vertigo

Eyes
- ❑ Glasses/contact lenses
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ Spots or floaters
- ❑ Eye inflammation
- ❑ Double vision
- ❑ Glaucoma
- ❑ Cataracts

Nose, Throat & Mouth
- ❑ Sinus infection
- ❑ Hay fever/allergies
- ❑ Frequent sore throat
- ❑ Difficulty swallowing
- ❑ Mouth & tongue ulcers
- ❑ Frequent colds
- ❑ Nosebleed
- ❑ Dry nose
- ❑ Nasal congestion
- ❑ Loss of voice
- ❑ Thirst
- ❑ TMJD
- ❑ Facial pain
- ❑ Dry mouth

Skin
- ❑ Hives
- ❑ Rashes
- ❑ Eczema/psoriasis
- ❑ Night sweating
- ❑ Excess sweating
- ❑ Dry skin
- ❑ Easy bruising
- ❑ Changes in moles, lumps
- ❑ Itching

Respiratory
- ❑ Difficulty breathing
- ❑ Difficulty breathing when lying down
- ❑ Wheezing
- ❑ Asthma
- ❑ Chronic cough
- ❑ Cough
- ❑ Coughing up phlegm
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Pneumonia

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain or tightness
- ❑ Palpitations
- ❑ Rapid heart beat
- ❑ Irregular heart beat
- ❑ Poor circulation
- ❑ Swollen ankles
- ❑ Phlebitis
- ❑ Anemia
- ❑ History of heart attack
- ❑ Heart murmur

Gastrointestinal
- ❑ Nausea
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Gall Bladder disorder
- ❑ Diarrhea
- ❑ Constipation
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Vomiting
- ❑ Gas
- ❑ Hiccups
- ❑ Acid regurgitation
- ❑ Bloating
- ❑ Bad breath
- ❑ Laxative use
- ❑ Bloody stool
- ❑ Mucus in stool
- ❑ Hemorrhoids
- ❑ Polyps

Musculoskeletal
- ❑ Joint pain/disorder
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Difficulty walking
- ❑ Neck/shoulder pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Rib pain
- ❑ Limited range of motion

Neurological
- ❑ Seizures
- ❑ Tremors
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Poor coordination

Genito-urinary
- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stones
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Pain/itching of genitalia
- ❑ Lumps in testicles

Infection Screening
- ❑ HIV risks: self or partner
- ❑ TB: self or household
- ❑ Hepatitis risk: self or partner
- ❑ History of sexually transmitted disease: self or partner
- ❑ Gonorrhea
- ❑ Chlamydia
- ❑ Syphilis
- ❑ Genital warts
- ❑ Herpes: oral/genital

❑ Other: ___________________