PATIENT HISTORY

1. What is your major complaint and how long has this condition persisted? _____

_____

2. Have you ever received any treatment for this condition? □ Yes □ No

If yes, where ? When ? and By whom?_____

What was the diagnosis? _____

What kind(s) of treatment(s)? _____

What were the results of treatment? _____

3. List medications you are currently taking.

Medications	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Please list substances that you are allergic to: _____

5. List any major surgeries and significant trauma you have had.

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Significant illness: (please check)

□ Rheumatic Fever □ Heart Disease □ Diabetes □ Hypothyroid □ Hyperthyroid
□ Hypertension □ Hepatitis □ Seizures □ Cancer □ HIV Positive
□ Tuberculosis ` Others_____

7. Does any of your relatives have the following diseases:

Rheumatic Fever _____ Heart Disease _____ Diabetes _____ Cancer _____
Hypothyroid _____ Hyperthyroid _____ Hypertension ____ Hepatitis _____
Seizures _____ HIV Positive _____ Tuberculosis ____ Others _____

8. Have you tried acupuncture or Chinese medicine before?
9. (Female only) Are you pregnant or do you suspect that you may be pregnant? Yes or No
How many children _____ Last period _____ Last pap-smear _____