EAST COUNTY ACUPUNCTURE

2160 Fletcher Parkway, Suite M, El Cajon, CA 92020

619/602-3366

PATIENTS PERSONAL HISTORY

Date_____

Name Date of Birth / / /

E-mail Phone

Address

City State Zip

Occupation Insurance Company

Emergency Contact Relationship

Phone

How were you referred to our office?

Have you ever had acupuncture? Yes No

If yes, condition treated

Have you ever been diagnosed with any of the following Hepatitis Yes No HIV Yes No

Please list any prescription medications

Medicatons

List any substances you are allergic to

List any conditions you would like us to focus on

Practitioner Notes:

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms, thus it is essential to indicate time on the symptoms.

Indicate with on check any condition that you sometimes experience, use two checks for those which occur often, and three checks for symptoms that area major concern.

WATER ELEMENT

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Lower back ache
- ☐ Neck pain
- ☐ Sinus congestion
- ☐ Edema
- ☐ Emotional instability
- ☐ Aversion to cold
- ☐ Hair thinning or loss
- ☐ Premature aging
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Perspire easily
- ☐ Weakness of legs/knees
- ☐ Asthmatic cough
- ☐ Rapid weight change
- ☐ Loose teeth
- ☐ Reduced sexual energy
- ☐ Thyroid problems
- ☐ Diabetes

WOOD ELEMENT

- ☐ Headaches
- ☐ Migraines
- ☐ Ringing in the ears
- ☐ PMS
- ☐ Irregular periods
- ☐ Eczema
- ☐ Herpes simplex
- ☐ Night sweats
- ☐ Warts
- ☐ Nervousness
- ☐ Convulsion, spasms
- ☐ Irritability
- ☐ Constipation
- ☐ Hemmorroids
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Vomiting
- ☐ Gallstones
- ☐ Indecisive
- ☐ Fullness below ribs
- ☐ Insomnia

FIRE ELEMENT

- ☐ Dry scalp
- ☐ Skin eruptions/rashes
- ☐ Cysts, tumors
- ☐ Ear infections
- ☐ Sore throat/tonsilitis
- ☐ Lymphatic swelling
- ☐ Hot palms/soles
- ☐ Strong appetite
- ☐ Flatulence
- ☐ Heart palpitations
- ☐ Aversion to heat
- ☐ Gum problems
- ☐ Nose bleed
- ☐ Itching/burning skin
- ☐ Hot hands/feet
- ☐ Thirst
- ☐ Vivid dreams
- ☐ Dark urine
- ☐ Stomach ulcer
- ☐ Diarrhea
- ☐ Sores in mouth
- ☐ Heartburn

EARTH ELEMENT

- ☐ Stomach ache
- ☐ Abdominal bloating
- ☐ Nausea
- ☐ Weak appetite
- ☐ Flatulence
- ☐ Muscle spasms
- ☐ Fatigue

METAL ELEMENT

- ☐ Bronchitis
- ☐ Asthma
- ☐ Cough
- ☐ Sinusitis
- ☐ Shortness of breath

WOMEN'S FERTILITY HISTORY

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Name _____ Date _____

Age when menses began _____

Have your cycles changed since they began? ☐Yes ☐No

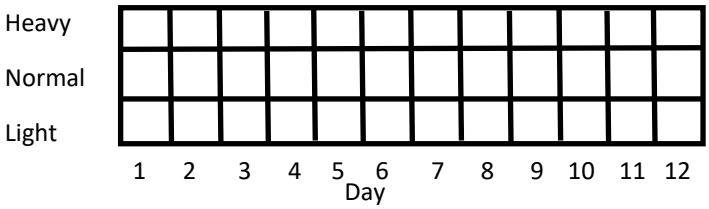
If yes, how often?_____

Are your periods painful? ☐Yes ☐No

If yes, how many days does the pain last?_____

How many days do your normally bleed?_____

How heavy is the bleeding?



What color is the blood? ☐Light red ☐Red ☐Dark red

☐Purple ☐Brown ☐Black

Is there clotting? ☐Yes ☐No

Do you have premenstrual tension? ☐Yes ☐No

Does your face break out before or during your period?

☐Yes ☐No

Does your breasts become tender? ☐Yes ☐No

Do you bleed or spot between periods? ☐Yes ☐No

Are your menstrual cycles irregular? ☐Yes ☐No

Date last menstrual cycle began_____

Have you ever had an abnormal pap smear ☐Yes ☐No

Number and Year_____

How many pregnancies have you had?_____/____

How many children do you have? _____/_____

How many abortions have you had_____ /_____

How many miscarriages have you had?_____/_____

How many times has a D&C been performed?_____/_____

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐Yes ☐No

Have you ever had a venereal disease? ☐Yes ☐No

Do you get yeast infections regularly? ☐Yes ☐No

Have you ever had chlamydia? ☐Yes ☐No

Do you have chronic vaginal discharge? ☐Yes ☐Yes

Do you have any sores on your genitalia? 2Yes ☐No

Have you had pelvic inflammatory disease? ☐Yes ☐No

If yes how were you treated for it? _____

_____

Date of last pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps

☐Yes ☐No

Have you been diagnosed with endometriosis?☐Yes ☐No

Have you been diagnosed with adhesions? ☐Yes ☐No

Have you ever been diagnosed with pelvic abnormalities?

☐Yes ☐No

Have you ever taken oral contraceptives? ☐Yes ☐No

When?_____How long?_____

Have you ever taken Depro Provera? ☐Yes ☐No

When_____How long?_____

Other contraceptives? ☐Yes ☐No

Medications	Reason	How long

WOMEN'S FERTILITY HISTORY

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How long have you been trying to conceive?_____

Have you had a diagnosis relating to fertility? ☐Yes ☐No

If yes, what was it?_____

Have you had fertility treatments? ☐Yes No

If yes, when_____

Where?_____

By whom?_____

What type?_____

Have you taken medication to help you ovulate? ☐Yes ☐No

If yes, what?_____

When?_____

How long?_____

Have your fallopian tubes been medically evaluated? ☐Yes ☐No

If yes, what were the results?_____

Have you had any tubal operations? ☐Yes ☐No

Have you had any hormone lab tests performed? ☐Yes ☐No

If yes, what were the results?_____

_____

_____

Have you been exposed to any known environmental toxins or hormones? ☐Yes ☐No

Are currently taking steroids? ☐Yes ☐No

How is your sexual energy? ☐Low ☐Normal ☐High

Do you have a single partner with whom you have been trying to conceive? ☐Yes ☐No

If yes, how long have you been together?_____

Has he had a fertility workup? ☐Yes ☐No

If yes, what were the result?_____

Is your partner supportive of your wish to conceive?

☐Yes ☐No

Do you douche regularly? ☐Yes ☐No

If yes, with what?_____

Do you use vaginal lubricants? ☐Yes ☐No

_____

Are you more than 20% over your ideal body weight?

☐Yes ☐No

Are you more than 20% under your ideal body weight?

☐Yes ☐No

Do you have a stressful occupation? ?☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Do you drink coffee, tea or sodas? ☐Yes ☐No

Have you ever taken oral contraceptives? ☐Yes ☐No

How much?_____

Do you smoke? ☐Yes ☐No

Do you have excessive facial hair? ☐Yes ☐No

Do you have excessively oily skin? ☐Yes ☐No

Have you noticed discharge from your nipples?

☐Yes ☐No

Practitioner Notes:_____

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