FLORIDA HOSPITAL ACUPUNCTURE
Patient History Form

Name: _____ DOB: _____ DOS: _____

Sex: □ Male □ Female Age: _____ Ht: _____ Wt: _____ Marital Status: _____
Address: _____
City: _____ State: _____ ZIP: _____
Home phone: _____ Work/Cell phone: _____
Email: _____
Occupation: _____
Employer: _____ Phone: _____

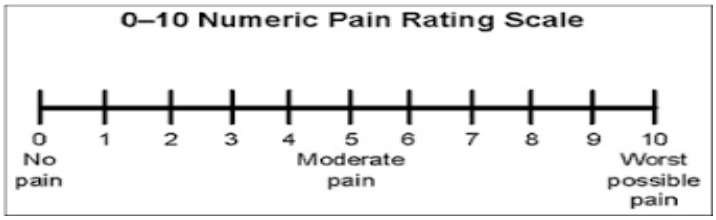
Emergency contact's name and phone: _____

Family Physician's name and phone: _____

How did you find us (circle): Webpage Physician Referral Friend Other: _____
Referred by: _____

Reason for your visit: _____
How long have you had this condition? _____
What seemed to be the initial cause? _____
Location: _____

Pain level: Rate the level of your pain by circling one number on the scale, where 0 means "no pain" and 10 means "worst pain imaginable".



Pain quality: □ achy □ dull □ throbbing □ sharp □ tingling □ numbness □ stabbing
Frequency of pain: _____
Aggravated by: _____
Alleviated by: _____

Have you ever been treated with acupuncture and/or herbal medicine before? □ Yes □ No

PAST MEDICAL HISTORY:
Childhood illnesses:
□ measles □ mumps □ chicken pox □ polio □ rheumatic fever
□ serious or chronic illness _____

Adult illnesses:
□ diabetes □ hypertension □ Tuberculosis □ arthritis □ stroke □ cirrhosis □ heart failure

Name: _____

Psychiatric illnesses: □ Anxiety □ Depression □ Stress

Obstetric/Gynecologic history:
□ Pregnancies _____ □ deliveries _____ □ abortion _____ □ gynecological illnesses _____

Hospitalizations/surgeries: _____

Injuries/Trauma: _____

Other Illnesses: _____

CURRENT MEDICATIONS: (prescriptions, over the counter, hormones, vitamins)

Name of Medication	Dosage	Duration

Allergies and Drug reactions: _____
Transfusions: □ Yes □ No
Hazardous exposures: □ asbestos □ solvents □ toxins □ fumes □ radiation

FAMILY MEDICAL HISTORY:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
_____	☐ Asthma	_____	☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

□ Other _____

HEALTH MAINTENANCE/DISEASE PREVENTION SCREEN:

Lifestyle habits: (check all that apply)
Regular Exercise: □ Yes □ No Type _____ Frequency _____
□ Alcohol _____ □ Marijuana □ Coffee/Tea _____
□ Tobacco _____ □ Other recreational drugs
□ Recreational activities _____
□ Sexually active

Name: _____

Diet:
Do you follow a specific diet? □ Yes _____ □ No
Dietary restrictions _____
Food cravings _____
What might you eat on a typical day?
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Vitamins & herbal supplements _____

Periodic Health examination:
Are you under the care of a physician now? □ Yes □ No if yes, for what? _____
Physician's name: _____ Physician's phone: _____
Other concurrent therapies: _____
Cholesterol: _____
Immunizations:
□ Childhood □ Travel □ Tetanus □ Influenza □ Hepatitis B
Cancer prevention:
□ PAP smear □ Mammogram □ Breast self-exam □ Skin care □ Colon cancer
□ Prostate cancer
Last date of Vision screening: _____
Last Visit for Dental care: _____
Last PAP Smear: _____ Last period: _____

Reproductive Health:
Prevention of STDs: _____
Contraception/Family Planning:
□ Birth Control pills □ Condoms □ Surgery _____
□ IUD □ Other hormonal birth control □ Other Non-hormonal birth control

Injury Prevention:
Use of seat belts: □ Yes □ No
Smoke detectors: □ Yes □ No
Firearm safety: □ Yes □ No
Family violence/ Domestic abuse □ Yes □ No _____
Other home hazards (poisons, hot water temperature, etc.) _____

REVIEW OF SYSTEMS: (check all that apply)

General Symptoms

□ Poor appetite	□ Poor sleep	□ Fever/chills
□ Heavy appetite	□ Heavy sleep	□ Weakness
□ Weight loss/gain	□ Fatigue	□ Other _____

Name: _____

Integument

□ Pruritis □ Rash/Lesions □ Hair/nail change

Hematopoietic

□ History of anemia □ Bleeding □ Bruising □ Lymphadenopathy

Eyes, Ears, Nose, Throat, Sinuses

☐ Glasses (age?)	☐ Night blindness	☐ Gum bleeding	☐ Recurrent sore throat	☐ Ringing in ears
☐ Eye strain	☐ Myopia/Presbyopia	☐ Sores on lips/tongue	☐ Rhinorrhea	☐ Hearing loss
☐ Eye pain	☐ Glaucoma	☐ Dry mouth	☐ Lumps in throat	☐ Earaches/drainage
☐ Red eyes	☐ Cataracts	☐ Excessive saliva	☐ Hoarseness	
☐ Itchy eyes	☐ Vision loss	☐ Teeth problems	☐ Sinus problems	
☐ Spots in eyes	☐ Eye Discharge/ tearing	☐ Grinding teeth	☐ Congestion/drainage	
☐ Blurred vision	☐ Taste in the mouth	☐ TMJ	☐ Nosebleeds	

Breasts

□ Masses □ pain □ discharge □ Other _____

Respiratory

□ Difficulty breathing while lying down □ Tight chest □ Asthma/wheezing □ Cough □ Color of phlegm: _____ □ Coughing up blood □ Pneumonia

□ Shortness of Breath □ Difficult inhale? Exhale? □ Sputum Production

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain □ Tachycardia □ Phlebitis

□ Blood clots □ Fainting □ Shortness of breath/cough at night

□ Heart palpitations □ Irregular heartbeat/ Afib □ Claudication □ Edema

□ Heart murmur □ Cyanosis □ Other _____

Gastrointestinal

□ Nausea	□ Diarrhea	□ Intestinal pain/cramps	□ Bowel changes
□ Vomiting	□ Constipation	□ Burning anus	□ Abdominal pain
□ Heartburn	□ Black stools	□ Melena	□ Other _____
□ Gas	□ Bloody stools	□ Anal fissures	
□ Hiccup	□ Mucous in stools	□ Difficulty swallowing	
□ Bloating	□ Hemorrhoids	□ Jaundice	

Urinary

□ Pain on urination	□ Blood in urine	□ Bedwetting	□ Kidney stone
□ Frequent urination	□ Unable to hold urine	□ Hesitance	□ Other _____
□ Urgent urination	□ Incomplete urination	□ Wake to urinate	

Name: _____

Genital/Reproductive

□ Testicular pain □ Sores/discharge □ Libido □ Sexual dysfunction

□ Vaginal discharge □ Irregular periods □ Vaginal discharge □ Sterility
□ PMS □ Clots
□ Menstruation:
Cycle duration_____ □ Painful periods □ Abnormal bleeding
□ Menopausal symptoms: _____

Endocrine

□ Thyroid issues □ Cold/heat intolerance □ Excessive thirst
□ Frequent urination □ Increased appetite □ Other _____

Musculoskeletal

□ Neck/shoulder pain □ Upper back pain □ Limited range of motion/use
□ Joint swelling □ Low back pain □ Muscle pain
□ Joint pain □ Rib pain □ Other _____

Skin and Hair

□ Rashes □ Eczema □ Dandruff □ Change in hair/skin texture
□ Hives □ Psoriasis □ Itching □ Fungal infections
□ Ulcerations □ Acne □ Hair Loss □ Other _____

Neuropsychological

□ Seizures □ Poor memory □ Irritability □ Considered/attempted suicide
□ Numbness □ Depression □ Easily stressed □ Seeing a therapist
□ Tics □ Anxiety □ Headaches □ Mood swings
□ Syncope □ Vertigo □ Double vision □ Tremors
□ Impaired coordination □ Memory loss □ Abnormal sensations
□ Neuropathic pain □ Sleep pattern _____ □ Nervousness

Signature: _____ Date: _____

Print Name: _____