Westchester Acupuncture and
Chinese Medicine Clinics
111 N. Central Ave. Suite 350, Hartsdale, NY 10530 (914) 562-5748

Patient Health History

Please print this form and bring to your initial visit. Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone _____ Mobile Phone: _____

Email: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____

Your Occupation: _____

Physician _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In Emergency Notify: _____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, etc.)

_____

_____

_____

_____

_____

_____

Significant Trauma (physical or emotional)

_____

_____

_____

Surgeries (please include date of procedure)

_____

_____

_____

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week _____Length of workout _____Type of Activity _____

Do you smoke? _____

Diet

Meals per day _____Snacks _____Caffeinated Drinks _____Alcohol per week _____

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood
- ☐ Diverticulitis/IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Diabetes ____
- ☐ High Blood Pressure ____
- ☐ Other_____
- ☐ Seizures ____
- ☐ Allergies ____
- ☐ Heart Disease ____
- ☐ Cancer ____
- ☐ Stroke ____
- ☐ Asthma ____

Please **check below** if you have had any of these items listed below in the last **year.** Put a **star** on the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure
- ☐ Pacemaker

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Production of phlegm what color? _____
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite Excessive

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Night urination… What time?_____ How often?_____
- ☐ Excessive libido

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Disease
- ☐ PMS
- ☐ Number of miscarriages_
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____
- ☐ Number of pregnancies_____
- ☐ Number of ectopic pregnancies_____
- ☐ Number of live births_____
- ☐ Number of abortions_____
- ☐ Do you practice birth control?___ What type?_____ How long?_____

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Muscle pain
- ☐ Bursitis
- ☐ Shoulder pain
- ☐ Sprains/Strains
- ☐ Muscle weakness
- ☐ Rotator Cuff
- ☐ Hand/wrist pain
- ☐ Sciatica
- ☐ Tendonitis
- ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain Hip pain
- ☐ Back Pain: Low___ Middle ____ Upper__

Neuropsychological

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/Panic attacks
- ☐ Nervousness
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper/irritable
- ☐ ADD/ADHD
- ☐ Vertigo/Dizziness
- ☐ Concussion
- ☐ Easily susceptible to stress
- ☐ Manic Depression
- ☐ Areas of numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder

Have you ever been treated for emotional problems? Yes___ No___

Have you ever considered or attempted suicide? Yes___ No___

Have you ever been treated for substance abuse? Yes___ No___

Comments Please inform me of any other problems you would like to discuss.