

ARTESIAN SPRING ORIENTAL MEDICINE

PATIENT HEALTH HISTORY

Name: _____
(first) (middle) (last)

Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Age: ____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care?

For what reason?

2. Please identify the health concerns that have brought you to Artesian Spring Oriental Medicine Clinic:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

5. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

6. Do you have any infectious diseases? Y N If yes, please identify: _____

7. Family History:

Father Mother Brothers Sisters Spouse Children

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

9. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

10. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

11. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Easily Angered Depression

13. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

14. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

15. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems: _____

16. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

17. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

18. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Dribbling Urination
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

19. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow
Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles
Menopausal Symptoms Difficulty Conceiving Painful Periods

20. Menstrual/Birthing History:

1. Age of First Menses: _____

4. Birth Control Type: _____

7. # of Abortions: _____

2. # of Days of Menses: _____

5. # of Pregnancies: _____

8. # of Live Births: _____

3. Length of Cycle: _____

6. # of Miscarriages: _____

21. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties

Prostrate Problems

Testicular Pain/Swelling

Penile Discharge

24. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain

Muscle Spasms/Cramps

Arm Pain

Upper Back Pain

Mid Back Pain

Low Back Pain

Leg Pain

Joint Pain (if so, where?): _____

If there is pain, what is the quality? Sharp/Stabbing

Dull/Achy

Constant

Intermittent

Fixed

Moving

25. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness

Paralysis Numbness/Tingling

Loss of Balance

Seizures/Epilepsy

26. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid

Hypoglycemia

Hyperthyroid

Diabetes Mellitus

Night Sweats

Feeling Hot or Cold

27. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia

Cancer

Rashes

Eczema/Hives

Cold Hands/Feet

Is there anything else we should know? _____

28. Lifestyle:

- a. Do you typically eat at least three meals per day? Y N If no, how many? _____
- b. Exercise routine: _____
- c. Spiritual practice: _____
- d. How many hours per night do you sleep? _____ Do you wake rested? Y N
- e. Level of education completed: High School BachelorsMasters DoctorateOther
- f. Occupation: _____ Employer: _____ Hours/Week: _____
- Do you enjoy work? Y/N Why/Why not? _____
- g. Nicotine/Alcohol/Caffeine Use: _____
- h. Have you experienced any major traumas? Y N Explain: _____
- _____
- i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- j. Television habits: _____ Reading habits: _____
- k. Interests and hobbies: _____

PRACTITIONER'S PAGE

Pulse:

Rate:

Right:

Left:

Differentiation/Diagnosis:

Treatment Plan:

Herbal Rx:

Recommendations: