Patient Health History

Artesian Spring Oriental Medicine, LLC

Full Legal Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ Work Phone:_____

Date of Birth:_____ Age:_____ Gender: ☐ M ☐ F Marital Status:_____

Occupation:_____ Hours per week:_____

Employer:_____ Email Address: _____

Emergency Contact:_____ Phone:_____ Relationship:_____

Referred by (so I can thank them!) or how you heard about me:_____

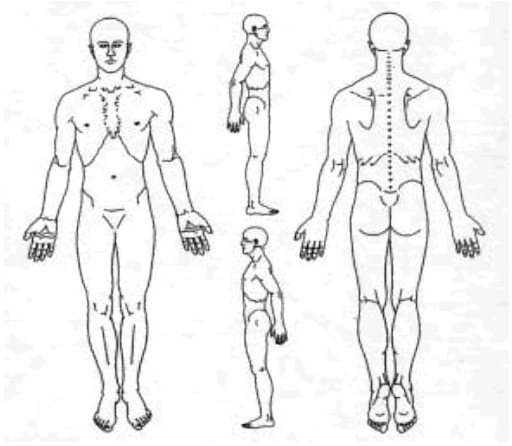
Chief Complaint:

Reason for visit:_____

_____

When did this condition begin?_____

Describe symptoms you have now (mark affected region on picture if applicable):



_____

_____

_____

_____

Please state diagnosis (if known):_____

What diagnostic tests (if any) have been done for this?_____

_____

What treatment(s) have you already received for this condition?_____

_____

_____

Has any treatment helped? (if yes, please explain)_____

_____

_____

Do you have any other health concerns? (please list in order of importance):

1)_____

2)_____

3)_____

4)_____

5)_____

Allergies:

Are you allergic or hypersensitive to any foods, drugs, or environmental allergens? Yes No

If yes, please describe:_____

Chronic Illness:

Do you have any infectious/contagious disease? Yes No

If yes, please explain:_____

Are you currently suffering from any chronic illness? Yes No

If yes, please explain:_____

Major Medical:

Please list all hospitalizations, surgeries, significant illnesses, or traumas you have experienced in your life:

1)_____ Date:_____

2)_____ Date:_____

3)_____ Date:_____

4)_____ Date:_____

5)_____ Date:_____

Current Medications:

Please list all prescription medications (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are currently taking and reason for taking them:

1)_____ dosage:_____ reason:_____

2)_____ dosage:_____ reason:_____

3)_____ dosage:_____ reason:_____

4)_____ dosage:_____ reason:_____

5)_____ dosage:_____ reason:_____

6)_____ dosage:_____ reason:_____

Nutrition:

Are you vegetarian or vegan? Yes No

Are you on any specific diets? Yes No If yes, please describe:_____

Other:

Do you smoke cigarettes? Yes No If yes, how many per day?_____

Do you drink alcohol? Yes No If yes, how many drinks per week?_____

Do you use cannabis / marijuana? Yes No If yes, how much and how often? _____

* **Are you pregnant or have any reason to believe you may be pregnant?** Yes No

Is there anything else you would like me to know about you?_____

_____

_____

Overall, the state of your health is: excellent good average fair poor

How much change are you willing to make for improving your health? minimal some complete