

MEDICAL SYMPTOMS HISTORY

Patient's Name: _____

Please make a check if you have experienced any on the following symptoms now or in the past. The more thorough you are with the following the better outcome you will have with your acupuncture treatment.

Symptom	Now	Past	Symptom	Now	Past	Symptom	Now	Past
<i>Skin</i>								
eczema	<input type="checkbox"/>	<input type="checkbox"/>	red face	<input type="checkbox"/>	<input type="checkbox"/>	never sweat	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>	face flushes	<input type="checkbox"/>	<input type="checkbox"/>			
cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	unusual sweating	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Heart</i>								
palpitation	<input type="checkbox"/>	<input type="checkbox"/>	short of breath	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>
<i>Ear, Nose & Throat</i>								
deafness	<input type="checkbox"/>	<input type="checkbox"/>	frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	itchy throat	<input type="checkbox"/>	<input type="checkbox"/>
tinnitus (ear ringing)	<input type="checkbox"/>	<input type="checkbox"/>	sinus headaches	<input type="checkbox"/>	<input type="checkbox"/>	constant sinus	<input type="checkbox"/>	<input type="checkbox"/>
itchy ear	<input type="checkbox"/>	<input type="checkbox"/>	yellow mucus	<input type="checkbox"/>	<input type="checkbox"/>	congestion		
ear pain	<input type="checkbox"/>	<input type="checkbox"/>	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	strep throat	<input type="checkbox"/>	<input type="checkbox"/>
sore throat	<input type="checkbox"/>	<input type="checkbox"/>	dry throat	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Gastrointestinal</i>								
constipation	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	ulcer	<input type="checkbox"/>	<input type="checkbox"/>
diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
no appetite	<input type="checkbox"/>	<input type="checkbox"/>	intestinal gas	<input type="checkbox"/>	<input type="checkbox"/>	ileocolic valve spasm	<input type="checkbox"/>	<input type="checkbox"/>
stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	belching	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Oral Disease</i>								
gums bleeding	<input type="checkbox"/>	<input type="checkbox"/>	mumps	<input type="checkbox"/>	<input type="checkbox"/>	toothache w/out cavities	<input type="checkbox"/>	<input type="checkbox"/>
peridontitis	<input type="checkbox"/>	<input type="checkbox"/>	inflammation of mouth	<input type="checkbox"/>	<input type="checkbox"/>			
dental abscess	<input type="checkbox"/>	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Focal Infections:</i>								
rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	connective tissue	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
arthritis	<input type="checkbox"/>	<input type="checkbox"/>	knee ligaments	<input type="checkbox"/>	<input type="checkbox"/>			

Symptom	Now	Past
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Vascular

dizziness Now Past

General

insomnia Now Past
 psychosomatic Now Past
 weakness Now Past
 hormone imbalance Now Past
 exhaustion Now Past
 emotional problems Now Past
 asthma Now Past
 bronchitis Now Past
 hypothyroid (low) Now Past
 hyperthyroid (high) Now Past
 low blood pressure Now Past

Other Symptoms

anemia Now Past
 easily catch cold Now Past
 swollen glands Now Past
 easily get carsick/seasick Now Past
 feels "spacey" Now Past

Medications & Drugs

Cigarettes Now Past
 Alcohol Now Past

Symptom	Now	Past
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migraine Now Past

high blood pressure Now Past
 diabetes Now Past
 hypoglycemia Now Past
 rheumatism Now Past
 colitis Now Past
 alopecia (baldness) Now Past
 allergies Now Past
male:
 impotence Now Past
 premature ejaculation Now Past
Female:

taking a long shower/bath makes you dizzy/faint Now Past
 difficulty concentrating Now Past
 no appetite for breakfast Now Past
 moody in morning Now Past

Cocaine Now Past
 Marijuana Now Past

Symptom	Now	Past
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headache with nausea Now Past

menstrual cramps Now Past
 menstrual clotting Now Past
 heavy periods Now Past
 light periods Now Past
 irregular periods Now Past
 PMS Now Past
 menopause symptoms Now Past

of pregnancies? _____
 # of births? _____

no energy before noontime Now Past
 energetic in eve, but hate the morning Now Past

Prescription Drugs: _____

Any other symptoms or disease? _____

Have you ever had any surgeries? If so, when where they? _____

What scars do you have? _____