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Oriental Medicine Questionnaire

Date _____

Name_____ DOB_____ Sex: M F

Address_____City_____State_____Zip_____

Cell Phone_____ Home Phone_____ Email_____

At which place(s) do I have permission to contact you? Cell / Home / Email

Emergency Contact_____Relationship_____

Occupation_____Height_____Weight_____

Name of your Physician_____

Who referred you to this office? _____

1. What brought you here today?_____

_____

_____

2. When did you first notice any problems related to your chief complaint and what symptoms did you notice?_____

_____

_____

3. Describe what has happened from the first symptoms until today_____

_____

_____

_____

4. What previous medical workups, diagnosis, and treatment have you had for this problem? How have these been helpful or not?_____

_____

_____

5. Please list any allergies to drugs or medications: _____

_____

6. What medications or supplements are you currently taking?

Medication	**Dose**	**How long have you been taking it?**

7. Other illnesses, surgeries, injuries:

Illnesses

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries/Trauma

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Family History

☐ Allergies ☐ Diabetes ☐Emotional Difficulties ☐Glaucoma ☐ Heart Problems ☐ Stroke

☐Cancer ☐Seizure Disorders ☐Tuberculosis ☐Thyroid Problems ☐Hypertension/High BP

Please check any conditions or symptoms that you presently have or have had in the past:

	Presently Have	Had in Past		Presently Have	Had in Past
Cough	☐	☐	Pneumonia	☐	☐
Cough with blood	☐	☐	Sputum/Phlegm	☐	☐
Shortness of breath	☐	☐	Asthma	☐	☐
Bronchitis	☐	☐	Lack of perspiration	☐	☐
Seasonal Allergies	☐	☐	Excessive perspiration	☐	☐
Chronic colds	☐	☐			
Nasal or sinus congestion	☐	☐	Nose bleeds	☐	☐
Sinus infections	☐	☐	Nasal Polyps	☐	☐
Loss of smell	☐	☐			
Irregular heartbeat	☐	☐	Chest pains	☐	☐
Poor circulation	☐	☐	Heart attack	☐	☐
Dizziness	☐	☐	Low blood pressure	☐	☐
Palpitations	☐	☐	*High blood pressure	☐	☐
Fainting spells	☐	☐	*treatment_____		

	Presently Have	Had in Past		Presently Have	Had in Past
Indigestion	☐	☐	Abdominal cramping	☐	☐
Nausea	☐	☐	Diarrhea	☐	☐
Vomiting	☐	☐	Constipation	☐	☐
Vomiting with blood	☐	☐	*Laxative use	☐	☐
Gas	☐	☐	*Product_____		
Bloating	☐	☐	Alternating diarrhea & constipation	☐	☐
Belching	☐	☐	Rectal Pain	☐	☐
Acid regurgitation	☐	☐	Hemorrhoids	☐	☐
Poor appetite	☐	☐	Blood in Stool	☐	☐
Excessive appetite	☐	☐	Bowel movements every_____days _____number of bowel movements/day		
Frequent urination	☐	☐	Burning on urination	☐	☐
Excessive urination	☐	☐	Difficulty urinating	☐	☐
Nighttime urination	☐	☐	Painful urination	☐	☐
Unable to hold urine	☐	☐	Blood in urine	☐	☐
Kidney stones	☐	☐	Sexually transmitted diseases	☐	☐
Bladder infections	☐	☐			
Muscle pain	☐	☐	*Joint pain	☐	☐
Muscle weakness	☐	☐	*Where_____		
Muscle spasms	☐	☐	Neck pain	☐	☐
Back pain (lower)	☐	☐	Knee pain	☐	☐
Back pain (middle)	☐	☐	*Numbness	☐	☐
Back pain (upper)	☐	☐	*Where_____		
Pain down leg(s)	☐	☐			
Wear glasses	☐	☐	Eye tiredness / strain	☐	☐
Blurred vision	☐	☐	Seeing spots	☐	☐
Double vision	☐	☐	Sensitivity to light	☐	☐
Cataracts	☐	☐	Eye dryness	☐	☐
Glaucoma	☐	☐	Eye redness	☐	☐
Eyes feel swollen	☐	☐	Eye itchiness	☐	☐
Pressure in the eye	☐	☐	Eye tearing	☐	☐
Eye pain	☐	☐			
Hearing difficulties	☐	☐	Loss of balance	☐	☐
Ringing in the ears	☐	☐	Ear infections	☐	☐
Ear pain	☐	☐			
Sore throats	☐	☐	Sore gums	☐	☐
Mouth dryness	☐	☐	Bleeding gums	☐	☐

	Presently Have	Had in Past		Presently Have	Had in Past
Bad taste in mouth	☐	☐	Sore tongue	☐	☐
Bad breath	☐	☐	Numbness in tongue	☐	☐
Mouth sores/ulcerations	☐	☐	Grinding teeth	☐	☐
Changes in the skin color	☐	☐	Dandruff	☐	☐
Skin bruising	☐	☐	Eczema	☐	☐
Skin rashes	☐	☐	Psoriasis	☐	☐
Skin acne	☐	☐	Skin ulcerations	☐	☐
Body hair changes	☐	☐			
Sudden weight loss	☐	☐	Sudden weight gain	☐	☐
Diabetes	☐	☐	Thyroid disorder		
Anxiety	☐	☐	Problems with alcohol/drug use	☐	☐
Depression	☐	☐	Psychological crisis	☐	☐
Irritability	☐	☐	Psychoactive medications	☐	☐
Hot tempered	☐	☐	if yes, which ones?_____		
Stress	☐	☐	Emotional difficulties	☐	☐
Fevers	☐	☐	Seizures	☐	☐
Chills	☐	☐	Concussion	☐	☐
Cold intolerance	☐	☐	Headache	☐	☐
General chilliness	☐	☐	Shaking / tremors	☐	☐
Cold hands and feet	☐	☐	Cysts / tumors	☐	☐
Heat intolerance	☐	☐	Edema / water retention	☐	☐
General warmth	☐	☐	Night sweating	☐	☐
Fatigue	☐	☐	Insomnia	☐	☐
Anemia	☐	☐	if yes, difficulty falling asleep / staying asleep?		
Poor memory	☐	☐	Nightmares	☐	☐

Smoking: How much per day? _____

Alcohol: How much per day? _____

Nutrition

What do you typically eat for the following:
Breakfast:_____

Lunch:_____

Dinner:_____

Exercise

What is your daily activity level related to your occupation?

☐ Sedentary (mostly sitting) ☐ Somewhat active ☐ Moderately active

☐ Very active (moving around or up most of the time) ☐ Heavy duty(lifting, moving things)

In what kind of physical activities (exercise, sports) do you participate? Intensity level? How often per week? How long each time?_____

_____

_____

Miscellaneous:

How much water do you drink per day? _____

How many caffeinated products (coffee, tea, carbonated pop) do you drink per day?

_____

Snacks: _____

Male Patients – please fill out the following section

Please check any conditions or symptoms that you presently have or had in the past

	Presently Have	Had in Past		Presently Have	Had in Past
Prostate enlargement	☐	☐	Premature ejaculation	☐	☐
Prostatitis	☐	☐	Impotence	☐	☐

Female Patients – please fill out the following section

Pregnancy:

Are you pregnant? Y N Not sure

Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), and/or abortions (A). Whether vaginal (V) or Cesarean section (C). Note any difficulities you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum, etc.)

Year

_____ _____

_____

_____ _____

_____

_____ _____

_____

Menstruation

Age of onset _____ Last Menstrual Period (first day)_____

Date of last Pap exam ____/____/_____ Result _____

Length of usual period _____days Length between periods _____

Regularity:

☐ regular ☐ irregular ☐ usually early by ____days ☐usually late by____days ☐varies between being early or late

Flow is: ☐ even ☐ uneven ☐ heavy ☐ light

Color is: ☐ pale ☐ pink ☐ light red ☐ red ☐deep red ☐purplish ☐brown

Consistency is: ☐ thin ☐thick ☐clotted

Discomfort with Period

☐ lower abdominal distention ☐before ☐during ☐after menstruation

☐ lower back soreness ☐before ☐during ☐after menstruation

☐cramping ☐before ☐during ☐after menstruation

☐other_____

Premenstrual Syndrome (PMS)

☐ irritability ☐bloating ☐mood swings ☐breast tenderness

☐other_____

Vaginal Discharge

☐ No ☐Yes If yes, color and amount: _____

Menopause

Age of onset_____ Any difficulties/symptoms? _____

Uterine bleeding (not related to periods)? No Yes Color_____ Amount_____

☐ comes on suddenly ☐all the time