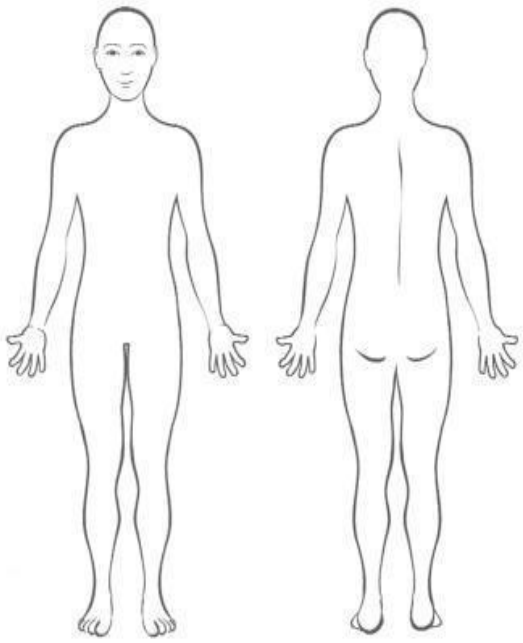
Oriental Medical Center, Mai Tar

Name _____ Date _____ Time _____ Account No. _____

Birth Date _____ Height _____ Weight _____

PLEASE MARK YOUR AREAS OF PAIN



Major Complaint/s _____

_____

_____

Other Complaints: _____

_____

Date of onset (when your first noticed your problem)? _____

Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

How long have you had this condition? _____

Have you had this in the past? ☐ Yes ☐ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

Medications/Drugs/Herbs you are currently taking: _____

_____

List of surgeries/Operations you have had and dates: _____

_____

Date of your last physical examination: _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): ☐ Arthritis ☐ Asthma ☐ Anemia ☐ Heart trouble ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ High blood Pressure ☐ Chronic Fatigue ☐ Hepatitis ☐ Jaundice ☐ Sudden weight loss ☐ Sudden weight gain

Other: _____

FAMILY HISTORY: (Has any member of you family had any of the above)? ☐ Yes ☐ No If yes, which member and what did they have?

ENERGY LEVEL: High (Time of day) _____ Low (Time of day) _____

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it? _____

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating _____

CIRCULATION: Feelings of ☐ Hot ☐ Cold What area? _____

☐ Bleed easily ☐ Cold limbs ☐ Other: _____

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Changing moles or lumps (cysts/tumors) ☐ Boils ☐ Frequent skin rashes ☐ Acne ☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled ☐ Bruises easily (black and blue spots) ☐ Hives ☐ Other: _____

SCARS: (List ALL scars from accidents or surgeries) _____

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Other: _____ How many hours do you sleep a night? _____

HEAD: Headaches (what area)? _____ ☐ Dizziness ☐ Memory loss ☐ Loss of balance

Other: _____

EYES: ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes ☐ Other: _____

EARS: ☐ Poor hearing ☐ Ear aches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears

Other: _____

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds ☐ Other: _____

THROAT: ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems ☐ Teeth/gum problems ☐ Swollen tongue

Other: _____

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing ☐ Trouble breathing at night

☐ Pain/pressure in chest ☐ Palpitations ☐ Persistent cough ☐ Coughing blood ☐ Coughing phlegm

Sputum color: _____ Consistency: _____

Other: _____

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools ☐ Hemorrhoids

☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems Number bowel movements a day: _____

Other: _____

URINE: Color: _____ Amount: _____ Frequent urination ☐ Daytime ☐ At night

☐ Strong smelling urine ☐ Hard to urinate ☐ Pain or burning on urinating ☐ Blood in urine

☐ Frequent infections ☐ Water retention Other: _____

MUSCULOSKELETAL: Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands ☐ Hip ☐ Knee

☐ Fingers ☐ Big toe ☐ Upper back ☐ Mid back ☐ Lower back ☐ Bones sore/painful ☐ Loss of grip

☐ Swollen knees/elbows ☐ Leg cramps at night ☐ Weakness in legs ☐ Weak ankles ☐ Stiff all over

☐ Tingling in feet ☐ Muscle spasm/cramps ☐ Loss of feeling in hands/feet ☐ Painful joints ☐ Bursitis

Other: _____

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequent crying

☐ Worry/Anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors

☐ Numbness/tingling in limbs ☐ Poor coordination ☐ Muscle weakness ☐ Feel weak and shaky ☐ Seizures

☐ Neuralgia (nerve pain) ☐ Shingles Other:

FEMALES: Pregnant? ☐ Yes ☐ No Last monthly period _____ Last PAP test _____

Form of birth control: ☐ None ☐ Pill ☐ Other: _____

Age started menstrual cycle _____ Age stopped _____ ☐ Menstrual pain ☐ Low backache

☐ Irregular Clotting ☐ Heavy bleeding ☐ Light scanty bleeding Color _____

☐ Water retention ☐ Mood changes ☐ Miss Periods ☐ Low or no sex drive ☐ Painful breasts ☐ Hot flashes

☐ Food cravings ☐ Other: _____

Discharge: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid ☐ Other: _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

No. Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries ☐ Other: _____

MALES: ☐ Low sexual drive ☐ Lack of sexual drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges

☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostrate trouble ☐ Other: _____

APPETITE: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed

☐ Excessive thirst ☐ Never thirsty ☐ Other: _____

Specific food cravings? ☐ Yes ☐ No If yes, what? _____

Other: _____

DIGESTION: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning/belching ☐ Stomach pain

☐ Stomach cramps ☐ Nausea ☐ Vomiting ☐ Bad breath ☐ Sores in mouth ☐ Weight gain ☐ Weight loss

☐ Bitter/sour taste in mouth ☐ Abdominal bloating How long after eating? _____

Food allergies? ☐ Yes ☐ No If yes, to what? _____

Other: _____

NUTRITION: List some of your favorite foods _____

_____

Do you ☐ Skip breakfast ☐ East a snack ☐ Eat a hearty breakfast

How many meals a day do you eat?_____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ☐ Yes ☐ No How often? _____

Do you plan your meals according to the “Four basic food groups” ☐ Yes ☐ No

How many glasses of water do you drink a day? _____ ☐ Filtered ☐ Bottled