

East West Medicine

Kim Nguyen, L. Ac.

Patient Name: _____ Date: _____

GENERAL

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> Sweats Easily |
| <input type="checkbox"/> | <input type="checkbox"/> Chills |
| <input type="checkbox"/> | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> Poor Coordination |
| <input type="checkbox"/> | <input type="checkbox"/> Change In Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Strong Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

CARDIOVASCULAR

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling Hands/Feet |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

FEMALE

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Frequent Urinary Tract Infections |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent vaginal infections |
| <input type="checkbox"/> | <input type="checkbox"/> Pain/Itching of Genitalia |
| <input type="checkbox"/> | <input type="checkbox"/> Genital Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> Pelvic Inflammatory |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular Periods |
| <input type="checkbox"/> | <input type="checkbox"/> Painful Menstrual Periods |
| <input type="checkbox"/> | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> Menopausal Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

SKIN AND HAIR

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> Hives |
| <input type="checkbox"/> | <input type="checkbox"/> Itching |
| <input type="checkbox"/> | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> | <input type="checkbox"/> Tumors, Lumps |

RESPIRATORY

- | Past | Current |
|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> | <input type="checkbox"/> COPD |
| (Chronic Obstructive Pulmonary Disease) | |
| <input type="checkbox"/> | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> Cough |
| <input type="checkbox"/> | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> | <input type="checkbox"/> Production of phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

NEUROLOGICAL

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> Numbness or Tingling of Limbs |
| <input type="checkbox"/> | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> | <input type="checkbox"/> Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

HEAD AND NECK

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

GASTRO-INTESTINAL

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Belching |
| <input type="checkbox"/> | <input type="checkbox"/> Blood in stools/black |
| <input type="checkbox"/> | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> Pain or Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> Gallbladder Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Gas |
| <input type="checkbox"/> | <input type="checkbox"/> Bloating |

PSYCHOLOGICAL

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Anxiety/Stress |
| <input type="checkbox"/> | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> Treated for emotional/psychological problems |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

EARS

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Infection |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing (low / high) |
| <input type="checkbox"/> | <input type="checkbox"/> Decreased Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> Discharge/Pus |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

INFECTION SCREENING

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> HIV |
| <input type="checkbox"/> | <input type="checkbox"/> TB |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> | <input type="checkbox"/> Herpes: oral/genital |

EYES

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> | <input type="checkbox"/> Poor Night Vision |
| <input type="checkbox"/> | <input type="checkbox"/> Spots |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> Glasses/Contacts |

MALE

- | | |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Pain/Itching of Genitalia |
| <input type="checkbox"/> | <input type="checkbox"/> Genital Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> | <input type="checkbox"/> Weak Urinary Stream |
| <input type="checkbox"/> | <input type="checkbox"/> Lumps in Testicles |

GENITO-URINARY

- | | |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> Pain on Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> | <input type="checkbox"/> Urgency to Urinate |
| <input type="checkbox"/> | <input type="checkbox"/> Unable to Hold Urine |

NOSE, THROAT AND MOUTH

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus Infection |

- | Past | Current |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Recurring Sore Throats |

- | Past | Current |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Grinding Teeth |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty Swallowing |