

***Welcome to East West Medicine*** ☺

***Kim Nguyen, L. Ac***

**Patient Health History Form**

Date:        /        /

Name:		Sex:	Date of Birth:	Age:
Address:		Apt:	City:	State      Zip Code
Home Phone #: (        )        -		Other Phone #: Work    Cell (        )        -		Email:
Relationship Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/ partner <input type="checkbox"/> Other <input type="checkbox"/>			Emergency Contact and Phone:	
Employer:			Occupation:	
Primary Care Physician and Phone #:		Are you presently under a doctor's care? Y / N With who and for what?		Are there any other therapies which you are involved? Y / N With who and for what?
Have you been treated by Acupuncture or Oriental Medicine Before? Y / N  If yes, when? ____/____/____			How did you hear of our clinic?	

<b>Health History</b>							
<i>Please check any conditions you or your family have had and include the year it began.</i>							
	Self	Mother	Father	Sister	Brother	Spouse	Child
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis							
Hypertension							
Heart Disease							
Stroke							
Seizures							
Thyroid Disorder							
Asthma							
Pacemaker							
Osteoporosis							
Herpes							
AIDS/HIV							
Rheumatic Fever							
Alcoholism							
Allergies							
Mental Illness							
Kidney Disease							
Anemia							
Age at Death							

What is the reason for your visit?

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When did this start? \_\_\_\_\_

How does this problem interfere with daily activities?

Work  Standing  Sexually

Sleep  Emotional  Recreation

Walking  Relationships  Bending

Sitting  Social Life  Stretching  Other  \_\_\_\_\_

Circle the severity level on a scale from 1-10 (1=no symptoms, 10=worst ever)

1      2      3      4      5      6      7      8      9      10

Please list all injuries, hospitalizations and surgeries and when it occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications, herbs or supplements that you take regularly (with dosage if applicable):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you or may you be currently pregnant? Y / N

# of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ premature \_\_\_\_\_ # of abortions/miscarriages \_\_\_\_\_

### Habits

Amount/Week? Year Began? Year Quit?

Coffee/Tea			
Soda			
Tobacco			
Alcohol			
Marijuana			
Cocaine/ Crack			
Other			

### Exercise

Do you exercise regularly? Y / N  
If so, what type and how often?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Diet

Generally, what do you eat for:

Breakfast\_\_\_\_\_

Morning Snack\_\_\_\_\_

Lunch\_\_\_\_\_

Afternoon Snack\_\_\_\_\_

Dinner\_\_\_\_\_

Have you ever had an eating disorder?  
Y / N