An Kang Acupuncture and Herbal Clinic
Patient Health History

Name: ____ Date: __________
(First) (Middle) (Last)

Date of Birth: __________________ Gender: _______ Marital Status: ________________

Street Address: ____

City: _______________________ State: ______________ Zip Code: _________

Home Telephone: ________________________ Work Telephone: __________________

Email Address: ____

Emergency Contact: __________________ Telephone: ______________Relationship:_______

How did you hear about us? ____

Successful health care and preventative medicine are only possible with the practitioner has a complete understanding of the patient physically, mentally, and emotionally. This survey will help us to evaluate your health more completely. Please complete this survey as thoroughly as possible. Include all the complaints, which are familiar to you. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Are you currently receiving health care? Y N If yes, where and from whom? ____________

____

If no, when and where did you last receive health care? ________________for what reason? _______

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to the An Kang Clinic below:

Condition	**Past Treatment**
a. ____________________________	____________________________

How does this condition affect you? ____

b. ____________________________	____________________________

How does this condition affect you? ____

c. ____________________________	____________________________

How does this condition affect you? ____

d. ____________________________	____________________________

How does this condition affect you? ____

4. What are your most important health problems? Please list in order of importance:

a. ___________________________________ c. ____

b. ___________________________________ d.____

5. Do you have any reason to believe that you are pregnant? Y N

6. Do you have any chronic infectious diseases? Y N If yes, please explain _________________________

7. Are you currently suffering from any chronic illness? Y N If yes, please explain____________________

8. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):____

9. Please circle any of the following medications that you are currently taking:

Laxatives Pain Relievers Antacids Thyroid Medication Appetite Suppressants
Antibiotics Tranquilizers Sleeping Pills Cortisone Blood Pressure Medication

10. Please list any prescription medications, over-the-counter medications, and supplements that you are currently taking:
1.____ 3. ____
2. ____ 4. ____

11. **Height**: ________ **Weight**: currently: ___________ Past Maximum Weight: __________ When: ________

12. **Blood Pressure**: What is your most recent blood pressure reading:___/___When was this reading taken___

13. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

14. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Other _________________________

15. **Hospitalizations and Surgeries**:

Reason	When	Reason	When

16. X-Rays/CAT Scans/MRI's/Special Studies:

Reason	When	Reason	When

17. **Family History**:

	Mother	Father	Brothers	Sisters	Children
Age if living:	______	______	_______	______	_______
Health (G=good, P=poor):	______	______	_______	______	_______
Age at death (if deceased):	______	______	_______	______	_______
Cause of death:	______	______	_______	______	_______

If applicable, check any conditions that members of your family have had below:

Cancer:	______	______	_______	______	_______
Diabetes:	______	______	_______	______	_______
Heart Disease:	______	______	_______	______	_______
High Blood Pressure:	______	______	_______	______	_______
Stroke:	______	______	_______	______	_______
Mental Illness:	______	______	_______	______	_______

18. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

19. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past)

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

20. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeding Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

21. **Respiratory** (Please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems: ____

22. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):
Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

23. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers   Changes in Appetite   Nausea/Vomiting   Epigastric Pain   Passing Gas
Heartburn   Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C
Hemorrhoids   Abdominal Pain

Stool: Diarrhea   Constipation   Undigested Food   Mucous   Blood In Stool

24. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease   Painful Urination   Frequent Urinary Tract Infections   Frequent Urination
Venereal Disease   Kidney Stones   Impaired Urination   Frequent Urination at Night
Blood in Urine

25. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles   Breast Lumps/Tenderness   Nipple Discharge   Heavy Flow
Bleeding Between Cycles   Vaginal Discharge   Clotting   Premenstrual Problems
Menopausal Symptoms   Difficulty Conceiving

26. **Menstrual/Birthing History**:

1. Age of First Menses: _______   4. Birth Control: _________   7. # of Abortions: _________

2. # of Days of Menses: ______   5. # of Pregnancies:_______   8. # of Live Births: ________

3. Length of Cycle: __________   6. # of Miscarriages: ______

27. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties   Prostate Problems   Testicular Pain/Swelling   Penile Discharge

28. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain
Low Back Pain   Leg Pain   Joint Pain (if so, where?):_________________________________

29. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

30. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

31. **Other**: (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Do you have any infectious diseases? Y N

if yes, please explain: ____________________

Is there anything else we should know? ____________________

32**. Life Style**:

1. Please indicate typical food intake:

   Breakfast: ____________________

   Lunch: ____________________

   Dinner: ____________________

   Snacks: ____________________

2. Daily Exercise: ____________________
3. Sleep Habits: ____________________
4. Education: ____________________
5. Occupation: ____________________ Employer ____________________Hr/Wk________
6. Do you enjoy work? Y N Why/Why not?____________________
7. Nicotine/Alcohol/Caffeine Use: ____________________
8. Have you experienced any major traumas? Y N Explain: ____________________

   ____

9. Consumption of Liquids: ____________________
10. Television Habits: ____________________
11. Reading Habits: ____________________
12. Interests and Hobbies: ____________________