Acupuncture and Chinese Herb Center

Confidential Patient Record

Please print and fill the registration form before you come to your first appointment.

Name: _____

Address: _____

Phone (day): _____ (evening)_____

Have you ever had the following illnesses? (Please circle yes or no for each)

Heart disease	Yes	No	Rheumatic fever	Yes	No
Anemia	Yes	No	Gonorrhea	Yes	No
Hepatitis	Yes	No	Syphilis	Yes	No
Gall bladder disease	Yes	No	Stomach ulcer	Yes	No
Cancer	Yes	No	High blood pressure	Yes	No
Colitis or other bowel disease	Yes	No	Hemorrhoid or other rectal disease	Yes	No
Nervous breakdown	Yes	No	Hay fever	Yes	No
Diabetes	Yes	No	Asthma	Yes	No

Other illness (if yes, please specify.) _____

Do you have now, or have you had within the past year any of the following? (Please circle yes or no for each)

Difficulty swallowing	Yes	No	Recurrent mouth sores	Yes	No
Chest pain	Yes	No	Coughed up blood	Yes	No
Wake up at night short of breath	Yes	No	Shortness of breath on walking several blocks	Yes	No
Shortness of breath on one flight of stairs	Yes	No	Shortness of breath on lying down	Yes	No
Palpitations or heart fluttering	Yes	No	Swelling of feet or ankles	Yes	No
Enlarged veins in leg	Yes	No	Recurrent stomach pain	Yes	No
Belching or heartburn	Yes	No	If yes, was the belching or heartburn relieved by food or medication?	Yes	No
Nausea or vomiting	Yes	No	Abdominal cramping	Yes	No
Need to avoid some foods (If yes, which food?) _____ _____	Yes	No	Change in size, shape or texture of bowel movement (If yes, describe.) _____ _____		
Blood with bowel movement	Yes	No	Rectal pain with bowel movement	Yes	No
Difficulty starting urinating	Yes	No	Painful urinating	Yes	No
Backaches	Yes	No	Blood in urine	Yes	No
Getting up in the night to urinate	Yes	No	Discharge from penis	Yes	No
(If yes, how many times?) _____	Yes	No	Excessive bleeding with cuts	Yes	No
Easy bruising	Yes	No	Tiredness with no apparent reason	Yes	No

Have you ever had a blood or plasma transfusion? Yes No

Have you ever undergone surgery? Yes No
If yes, for what reason? _____ Date _____

Have you ever been hospitalized for any illness? Yes No

What is your current weight? _____ lbs. Your height? _____

Do you smoke? Yes No
If Yes, how many packs per day? _____

Describe your appetite. good fair poor

Do you drink alcohol? Yes No
If yes, how many drinks per week?_____

Do you use drugs? Yes No

Current medications:

Drug name_____	Drug name_____
Dosage_____	Dosage_____
Frequency_____	Frequency_____

Are you allergic to any of the following? (Please circle yes or no for each.)

Penicillin	Yes	No	Aspirin	Yes	No
Codeine	Yes	No	Morphine	Yes	No
Dye	Yes	No	X-ray	Yes	No
Adhesive (If yes, Which Type?) _____	Yes	No	Any other drugs (If yes, Please list.) _____ _____	Yes	No

How often do you use the following? (Please circle the correct response for each.)

Laxatives	Never	occasionally	frequently	daily
vitamins	Never	occasionally	frequently	daily
Tranquilizers	Never	occasionally	frequently	daily
Tylenol	Never	occasionally	frequently	daily

Has any <u>blood relative</u> of yours ever had any of the following? (Please circle yes or no for each)

Cancer	Yes	No	Gallbladder disease	Yes	No
Diabetes	Yes	No	Heart trouble	Yes	No
High blood pressure	Yes	No	Stroke	Yes	No

Menstrual Cycle and related information – for women only to complete.

Age of onset of menstrual cycle: ____
Are your periods regular? Yes No Varies
How many days from start of one cycle to start of next cycle? _____
Date of last period: _____
Date of last pelvic exam: _____
Date of last pap test: _____
Results of test: negative positive
Do you experience discharge from your nipples? Yes No