

PATIENT HISTORY

Fill out the information requested below to the best of your ability.

1. Chief Complaint:

2. Please list your medical history (diagnosis and surgeries) and give the approximate dates of your history.

3. Please list the date and physician of your last physical _____

4. Family History: Does any member of your family, now or in the past, have a similar condition?

5. Other information related to Chinese Medicine:

A. Compared to your others, do you feel: () Cold () Hot () Normal

B. Urination () Many times at night () Painful () Several times but less amounts () Less () Difficult
() Yellow () Clear () Deep Yellow () Red (with blood) () Normal

C. Bowel Movement () Loose () Difficult () Painful () Dark Color () With Blood () Normal

D. Emotions () Depression () Anxiety () Easy to Change () Stress () Normal

E. Energy Level () Low () High () Changes often () Normal

F. Sleep () Not enough () Insomnia () Insomnia at times () sleep too much () insomnia all the time () normal

G. Do you have: () chills () fever () night sweats () thirst () poor appetite