MARYLAND ACUPUNCTURE CLINIC

Helping you live a healthier life

MEDICAL HISTORY QUESTIONNAIRE

Your responses on the attached form will help us optimize your treatment plan.
BRING COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT.

MARYLAND ACUPUNCTURE CLINIC
Medical History Questionnaire

Date: _____

Name: _____ Birth: _____ Age: _____ Gender: _____ Blood type: _____

Height: _____ / Weight: _____ Blood Pressure: ____ Cholesterol: _____

LDL – HDL: _____

PRESENTING HEALTH PROBLEM(S) & DESCRIPTION

TREATMENTS & RESULTS

HISTORY OF PRESENT ILLNESS: *Describe how and when the problems began and progressed*

CURRENT MEDICATIONS: DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

CURRENT SUPPLEMENTS: DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

DRUG ALLERGIES: *List and describe reactions to drugs, medications, or anesthetics.*

Allergies to Foods?
□ Milk products
□ Wheat or other grains
□ Food dyes, additive
□ Others

Allergies to Inhalants?
□ Dust
□ Grass, trees, pollen
□ Animal dander
□ Mold

Reactions to Chemicals?
□ Chlorine, formaldehyde
□ Cosmetics, detergents, perfumes
□ Gas, glues, newsprint. paint, dye
□ Smoke

INJURIES (SPRAINS, FRACTURES, SURGERIES DISLOCATIONS & SCARS) DATE

HOSPITALIZATIONS DATE

TEST:	DATE / RESULTS:	TEST:	DATE / RESULTS:
□ EEG		□ CT Scan	
□ EKG		□ MRI	
□ EMG		□ Stress Test	
□ SCAN		□ X-rays	

FAMILY HISTORY: check any which has affected your parents, grandparents, siblings, and/or children.

Condition	Relative/s Affected	Condition	Relatives Affected	Condition	Relatives Affected
□ Addiction(s)		□ Depression		□ High Blood P.	
□ Allergies		□ Diabetes		□ Lung Problem	
□ Arthritis		□ Digestive/Intest.		□ Overweight	
□ Asthma		□ Genetic Disease		□ Stroke	
□ Bladder		□ Gout		□ Thyroid	
□ Kidney		□ Headache		□ Suicide	
□ Bleeding		□ Migraine		□ Other	
□ Cancer		□ Heart Disease		□ Other	

YOUR HISTORY: Check any of the following that you have now or ever have had.

□ Alcoholism	□ Emphysema I Asthma	□ Muscle Problems	□ Thyroid: Hypo: □ Hyper □
□ Arthritis	□ Epilepsy/Seizures	□ Neurological Problem	□ TMJ / Jaw Dysfunction
□ Anxiety/Depression	□ Eye Problem	□ Psychological Problem	□ Viral: Herpes: □ CMV: □
□ Autoimmune Disease	□ Genetic Condition	□ Respiratory Problem	Polio: □ Mono: □
□ Bladder/Kidney	□ Headaches	□ Rheumatic Fever	□ Weight Loss
□ Cancer	□ Heart Disease	□ Scarlet Fever	How much? __ Time? ___
□ Digestive Problems	□ High Blood Pressure	□ Sexually Trans. Dis.	□ Weight Gain:
□ Diabetes	□ HIV/AIDS	□ Sinus/Upper Resp.	How much? __ Time? ___
□ Ear Infections/Problem	□ Hormonal	□ Stroke	□ Other _____
□ Eczema/Skin Problem	□ Intestinal Problems	□ Swallowing Problem	_____

Exams	Last Complete Physical ?	Results	By whom?
	_____	_____	_____
	Hemoccult (blood in stool)?	Results	By whom?
	_____	_____	_____
	Last Sigmoidoscopy of colon?	Results	By whom?
	_____	_____	_____

Females
Last menses? _____ Menopause? □ Yes □ No # of pregnancies __ # of children___
Pregnant? □ Yes □ No
Last Mammogram? _____ Results? _____ Last Pap Smear: _____ Results? _____
Last Breast Exam? _____ Results? _____ Breast Self Examination?
Frequent urination: □ Yes □ No Incontinence: □ Yes □ No
Libido: □ normal □ decreased □ increased Additional: _____

Males
Prostatitis: □ Yes □ No Last Prostate Exam: _____ Result:: _____
Frequent urination: □ Yes □ No Incontinence: □ Yes □ No
Libido: □ normal □ decreased □ increased Additional: _____

Children
Learning problems: □ Yes □ No Poor attention span: □ Yes □ No
Hyperactivity: □ Yes □ No Behavior problems: □ Yes □ No

ACTIVITY LEVEL:
□ Sedentary (inactive) by choice
□ Sedentary (inactive) due to inability or restriction
□ light: light daily work and no regular exercise
□ Moderate: light daily work and exercise 3 X week
□ Sustained: moderate daily work and exercise 5 X week
□ Heavy: heavy work and heavy exercise 5 X week

STRESSORS AFFECTING YOUR LIFE:
□ Difficulties with work or lifestyle
□ Recent change in marital status
□ Death or serious illness family or friend
□ Dysfunctional family □ Past □ Present
□ Lack of love or fulfilling relationships
□ Illness - self!

DIETARY HISTORY: How many servings and how often do you eat the following foods?

Dairy:	Milk, Cheese, Cottage Cheese, Yogurt	□ Cow □ Goat	□ Daily □ Weekly □ Rare/Never
Protein:	Chicken, Turkey	□ Fried	□ Daily □ Weekly □ Rare/Never
	Beef, Lamb, Pork, Veal, Liver		□ Daily □ Weekly □ Rare/Never
	Bacon, Bologna, Ham, Hot Dogs, Deli Meats		□ Daily □ Weekly □ Rare/Never
	Scale fish, Shell Fish. Mollusks	□ Fried	□ Daily □ Weekly □ Rare/Never
	Bean. Peas. Lentils. Soy, Tofu, Nuts Seeds		□ Daily □ Weekly □ Rare/Never
Grains:	Bread. Pasta, Crackers. Rice. Cereals	□ White □ Whole Grain	□ Daily □ Weekly □ Rare/Never
Vegs:	Greens: Broccoli, Spinach. Kale. Lettuces	□ Raw □ Cooked	□ Daily □ Weekly □ Rare/Never
	Yellow: Carrots, Squash. Yams. Tomato		□ Daily □ Weekly □ Rare/Never
	Other: Potato, Beet, Celery. Artichoke, etc	□ Raw □ Cooked	□ Daily □ Weekly □ Rare/Never
Fruits:	All varieties		□ Daily □ Weekly □ Rare/Never
Sweets:	Cookies, Candy, Pastry, Jam, Syrup		□ Daily □ Weekly □ Rare/Never
Oils:	Mayonnaise, Dressing. Oils	□ Natural □ Processed	□ Daily □ Weekly □ Rare/Never
Fats:	Fats: Hydrogenated (margarine, Crisco). Butter	□ Hydrog □ Butter	□ Daily □ Weekly □ Rare/Never
Other:	Ketchup. Steak Sauce, Soy Sauce		□ Daily □ Weekly □ Rare/Never
Drink:	Water		□ Daily □ Weekly □ Rare/Never
	Natural Vegetable, Fruit Juices		□ Daily □ Weekly □ Rare/Never
	Soft Drinks	□ Caffeine □ Decaf	□ Daily □ Weekly □ Rare/Never
	Coffee, Teas	□ Caffeine □ Decal	□ Daily □ Weekly □ Rare/Never
	Alcohol: Beer. Wine. Coolers, Hard Liquor		□ Daily □ Weekly □ Rare/Never

Is your diet primarily □ Natural / Organic □ Prepared at Home □ Commercially Prepared □ Fast Food

What diet is best for you? _____

ADDITIONAL INFORMATION: Please attach any information you feel would be helpful.

Review of Systems

Past - check (√) if applicable

Now - Rate as follows:
0 = Not present
1 = Mild
2 = Moderate
3 = Severe

Symptoms	Past	Now	Comments
General / Immune			
Frequent Fatigue			
Hot / Heat Intolerant			
Cold/ Cold Intolerant			
Perspire Easily			
Lack of Perspiration			
Frequent Infections			
Immune / Auto-immunity			
History of "Mono"			
Swollen Glands			
Endocrine			
Low body temperatures			
Cold Extremities			
Thyroid Disorder			
Dizzy Upon Standing			
Low Blood Pressure			
Skin/ Nails			
Acne, Eczema, Dermatitis			
Brown Spots			
Gooseflesh / Folliculitis			
Hives / Rashes			
Itch Burning, Dry			
Oily			
Pale			
White Spots: Loss of Pigment			
Yellow Tone			
Nails: Brittle, Peeling			
Ridges			
White Lines			
Head and Neck			
Headaches			
Migraines			
Head injury			
Face / Jaw Pain			
Neck Pain, Stiff Neck			
Hair. Brittle Dry			
Hair Loss of Color			
Hair Loss			
Eyes			
Wear Glasses			
Blurred Vision			
Blood Shot			
Burning / Dry / Itching			
Cataracts			
Floaters (see Spots)			
Glaucoma / Retina Problems			
Light Sensitive			
Night Blind			

Symptoms	Past	Now	Comments
Ears			
Ear Infections			
Itching			
Hard Ear Wax			
Ringing /Tinnitus			
Nasal			
Bleeds			
Burning / Dryness / Crusts			
PND/ Rhinitis			
Sinusitis			
Sense of Smell Loss			
Mouth/Throat			
Bleeding Gums			
Bone Loss (Periodontitis)			
Bruxism (Grinding)			
Face / Jaw Pain / TMJ			
Fillings: Silver / Mercury			
Lip Cracks			
Mouth Ulcers			
Swallowing Problem			
Taste Loss			
Tongue coated			
Tongue Fissured			
Voice Hoarse			
Digestive			
Belching, Bloating, Gas			
Colitis / Irritable Bowel			
Constipation			
Diarrhea			
Gastritis, Pain, Ulcer			
Heartburn, Reflex			
Hemorrhoids/Rectal Bleed			
Liver/Gall Bladder			
Nausea / Vomiting			
Stool: Dark green / black			
Blood			
Mucous			
Yellow			
Respiratory			
Asthma			
Bronchitis			
Cancer - Lung			
Chemically Induced Prob.			
Chest pain			
Colds + Flu (frequency)			
Cough - chronic			
Exercise Induce Problems			
Shortness of Breath			

Review of Systems (continued)

Symptoms	Past	Now	Comments
Cardiovascular			
High Blood Pressure			
Chest Pain			
Dizzy Spells			
Leg Pain With Walking			
Numb Extremities			
Palpitations / Tachycardia			
Stroke			
Varicosities			
Muscles & Joints			
Arthritis/Joint Pain			
Back Pain / Disc Problems			
Bursitis/Tendonitis			
Muscle Aches / Pains			
Muscle Cramps / Spasms			
Muscle Weakness			
Neurological			
Clumsy			
Convulsions / Seizures			
Fainting Spells			
Neuralgia I Tingling			
Numbness			
Reynaud's			
Spastic Motion / Tremors			
Urinary			
Bladder Infectious - frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Kidney Stones			
Pain, Burning			
Behavioral & & Psychological			
Addictions (list)			
Anxiety			
Attention Deficit (ADD)			
Bizarre Behavior			
Depression			
Developmental Delays			
Eating Disorder (list)			
Fearful / Worrier			
Hyperactive / Manic			
Insomnia			
Lack of Dream Recall			
Learning Problems			
Memory Problems			
Mood Swing			
Narcolepsy - Oversleeping			
Obsessive / Compulsive			
Phobias			
Schizophrenia			
Suicidal			

Symptoms	Past	Now	Comments
Male			
Discharge			
Impotence			
Lumps			
Pain- Testicular			
Prostate Problems			
Weak Urine Stream			
STD's			
Female			
Breasts: Cancer			
Fibrocystic			
Sore			
Endometriosis			
Fibroids / Cysts			
Hormone Replacement			
Hot Flashes			
Periods: Cramps			
Heavy Flow			
Irregular			
Infertility			
Peri-menopausal			
Menopausal: Natural			
Surgical			
Night Sweats			
Osteoporosis			
Ovarian/Uterine Cancer			
Painful Intercourse			
Pap Smears - abnormal			
Pre-Menstrual Tension			
Pregnancies: Incomplete			
Full Term			
Sexually Transmitted Dis.			
Vaginal: Dryness			
Infection			
Inflammation			
Yeast			
Discharge			
Spotting			
Foods / Glucose Tolerance			
Afternoon Drowsiness			
Cravings : Butter/Fats			
Foods (list)			
Ice			
Fatigue After Eating			
Hunger Headaches			
Hunger Irritability			
Skin Crawling Sensations			
Symptoms from Foods			

OTHER

Best time of day: _____

Worst time of day: _____

Best season for you: _____

Worst season for you: _____