

Lynn Drittenbas, L.Ac.
Patient History Form

Name: _____
(first) (middle) (last)

Date: ____/____/____

Address: _____

Phone Number: _____ Email: _____ Date of Birth: ____/____/____

Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. 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 your current health concerns in order of importance 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. If applicable, please list any foods, drugs or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N If so, how many weeks?: _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History:

Father

Mother

Brothers

Sisters

Please check those applicable:

Health (G=Good, P=Poor)

Cancer

Diabetes

Heart Disease

High Blood Pressure

Stroke

Mental Illness

Asthma/Hay Fever/Hives

Kidney Disease

Age (at death)

Cause of Death

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox Polio

12. Hospitalizations and Surgeries:

Reason

When

Reason

When

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. X-Rays/CAT Scans/MRIs/NMRs/Special Studies:

Reason

When

Reason

When

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Sports Injuries:

Type of Injury and Treatment

Current Status of Injury

_____	_____
_____	_____
_____	_____

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

Mood Swings Depression Anxiety Insomnia Frequent or Uncontrollable Anger Phobias

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

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose and Throat** (please circle any that you experience now and underline any 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 Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Allergies

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

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Bronchitis Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any 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

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

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hemorrhoids Abdominal Pain Acid Reflux Bloating

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

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

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

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

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____
2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____
3. Length of Cycle: _____ 6. # of Miscarriages: _____

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

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any 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?): _____

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

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

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

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

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

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Arthritis

Is there anything else we should know? _____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine/Drug Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Interests and hobbies: _____

How did you hear about our acupuncture services? _____
Would you like to receive our email newsletter? _____