**Medical History Questionnaire**

*Please complete the following as accurately as possible.*

Name:X_____ Date: ___ ___ ___

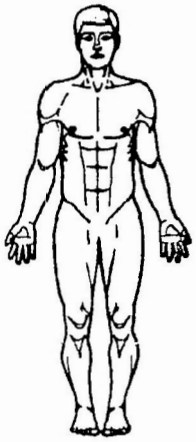
**Present Illness:**

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Mark with an X where you feel pain or discomfort.



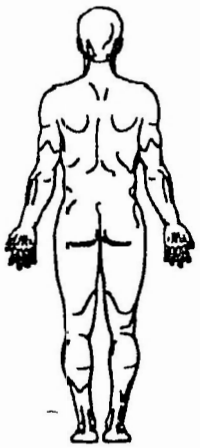
**Medical History:**

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?



**Have any of your blood relatives had any of the following?**

- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Bleeding disorders
- ☐ Diabetes
- ☐ High blood pressure

**How did you hear about Dr. Lord's Acupuncture Clinic? _____**

*Please complete the following as accurately as possible.*

Indicate if you have had any of the following:

- ☐ Cold sores
- ☐ Genital herpes
- ☐ Epstein Barr virus (EBV)
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ Epilepsy or convulsions
- ☐ Kidney disease
- ☐ Urinary bladder problems or infections
- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Respiratory
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Pancreatitis
- ☐ Anemia or other blood disorder
- ☐ Bleeding disorder
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hernia
- ☐ Thyroid disorder
- ☐ Hemorrhoids
- ☐ Sexually transmitted diseases
- ☐ Disorder of the genitals
- ☐ Gynecological disorder
- ☐ Congenital abnormalities
- ☐ Skin diseases
- ☐ Cardiac pacemaker
- ☐ Surgical implants
- ☐ Change in bowel or bladder habits
- ☐ Sores that will not heal
- ☐ Unusual bleeding or discharge
- ☐ Indigestion
- ☐ Colitis
- ☐ Crone's disease
- ☐ Irritable bowel disease
- ☐ Gall stones
- ☐ Lupus erythmatosis
- ☐ Difficulty swallowing
- ☐ Obvious change in a wart or mole
- ☐ Cough
- ☐ Hoarseness
- ☐ History of smoking
- ☐ History of smokeless tobacco use
- ☐ History of drinking alcohol
- ☐ History of recreational drug use
- ☐ History of sexually transmitted disease
- ☐ Hiv/ AIDS

Menstrual History: Started Menopause when?_____

Age of your first period:_____

Vaginal discharge: _____

Length of cycle, day 1 to day 1_____

Length of flow (days): _____

Date of your last period:_____

Do you believe you are pregnant? Yes No

Do you have any of the following:

- ☐ Menstrual cramps
- ☐ Menstrual blood clots
- ☐ Excessive bleeding
- ☐ PMS
- ☐ Breast swelling
- ☐ Breast pain
- ☐ Breast cysts
- ☐ Emotional changes with period
- ☐ Hot flashes
- ☐ Vaginal yeast (*Candida)* infections

Urology History:

- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Infertility
- ☐ Prostate problems

**Patient Confidentia. rmation**

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone ( ) _____

Age _____ Date of Birth ____/____/____ Sex M F * Marital Status S M D W
MM DD YY

Business Phone # _____

*Occupation or profession _____ *Employer _____

Emergency contact: _____
Name Relation Phone #

email: _____

**INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist or acupuncture interns and/or other licensed acupuncturists or acupuncture interns who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

*To be completed by the patient:*

Patient Signature _____ Date _____

Acupuncturist _____ Date _____