

# PATIENT HEALTH HISTORY FORM



## IDENTIFICATION DATA

Name _____	Today's Date _____
Address _____	Date of Birth _____ Age _____
City/Zip _____	Place of Birth _____
Home Phone _____	Business Phone _____
Mobile Phone _____	Email Address _____
Gender _____	Ethnicity _____
Education _____	Occupation _____

## FAMILY HISTORY

	FATHER	MOTHER	SIBLING	CHILDREN	OTHER
Allergies					
Blood Disorder					
Diabetes					
Cancer/Tumors					
Seizures					
High Blood Pressure					
Kidney/Bladder					
Stomach/Intestinal					
Drug Abuse					
Tuberculosis					
Heart Disorder					
Stroke					
Other					
Age of Death					

## PERSONAL HEALTH HISTORY

Allergies	(Food / Drug)	Asthma	Cancer	Hepatitis	Diabetes	Thyroid
Digestive	Tuberculosis	Seizures	Stroke	High Blood Pressure	Other	

Hospitalizations \_\_\_\_\_

Date \_\_\_\_\_ Illness \_\_\_\_\_ Hospital/Clinic \_\_\_\_\_

Pregnancy History / Number of Children \_\_\_\_\_

\_\_\_\_\_

Reason for seeking treatment today \_\_\_\_\_

\_\_\_\_\_

## REFERRAL INFORMATION

Referred by: \_\_\_\_\_

MEDICATIONS/SUPPLEMENTS CURRENTLY TAKING			
HABITS	CURRENT	PAST	FREQUENCY
Cigarettes			
Marijuana			
Recreational drugs			
Prescription drugs			
Alcohol			
Caffeine			
<b>DIET</b>	(List foods eaten on a typical day)		
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Restrictions			
Cravings			

DATE OF LAST PHYSICAL EXAM
Name of Doctor _____
Address _____
Phone _____

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that (patient) \_\_\_\_\_ has been advised by Abbey Fromkin, L.Ac. to consult a physician regarding the condition(s) for which above named patient seeks acupuncture and/or herbal medicine treatment.

\_\_\_\_\_  
(patient's signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(L.Ac.'s signature)

\_\_\_\_\_  
(date)