

# 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                                 |                                      |      |           |
| DIET                                     | (List foods eaten on a typical da y) |      |           |
| Breakfast                                |                                      |      |           |
| Snack                                    |                                      |      |           |
| Lunch                                    |                                      |      |           |
| Snack                                    |                                      |      |           |
| Dinner                                   |                                      |      |           |
| Snack                                    |                                      |      |           |
| Restrictions                             |                                      |      |           |
| Cravings                                 |                                      |      |           |

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

While Oriental Medicine has a gr eat deal to offer as a health ca re system, it cannot totall y replace the resources available through biomedical physicians. Consequently, it is r ecommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine tr eatment.

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 tr eatment.

\_\_\_\_\_ (patient’s signature) \_\_\_\_\_ (date)

\_\_\_\_\_ (L.Ac.’s signature) \_\_\_\_\_ (date)