

o+Oriental Medicine Questionnaire

Date: _____
Name: _____ DOB _____ Sex: M F SS# _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: _____ Home Phone: _____ Business Phone _____
Emergency Contact: _____
Occupation: _____ Height: _____ Weight: _____
Name of your Physician _____

Who referred you to this office? _____

1. What brought you here today?

2. When did you first notice any problems related to what brought you here today and what symptoms did you notice?

3. What happened since you first noticed any symptoms and up to today?

4. What previous medical workups, diagnosis and treatment have you had for this problem? How have these been helpful or unhelpful?

5. Please list any allergies to drugs or medications:

6. What medications or supplements are you currently taking:

Medication Dose How long have you been taking it

7. Other illnesses, surgeries, injuries

Illnesses

<u>Year</u>	<u>Illness</u>	<u>Treatment/ medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

<u>Year</u>	<u>Surgery</u>	<u>Outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injuries / trauma

<u>Year</u>	<u>Injury / Trauma</u>	<u>Treatment</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Family history

- Allergies Diabetes Emotional Difficulties Glaucoma Heart Problems Stroke
 Cancer Seizure Disorders Thyroid Problems Tuberculosis Hypertension/ High BP

Please check any conditions or symptoms that you presently have or have had in the past

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Cough with blood	<input type="checkbox"/>	<input type="checkbox"/>	Sputum/phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Chronic colds	<input type="checkbox"/>	<input type="checkbox"/>			
Nasal or sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	* High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	* treatment _____		
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>

Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting with blood	<input type="checkbox"/>	<input type="checkbox"/>	* Laxative use	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	* Product _____		
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea and constipation	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Presently</u>	<u>Had in</u>		<u>Presently</u>	<u>Had in</u>
	<u>Have</u>	<u>Past</u>		<u>Have</u>	<u>Past</u>
Acid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements every _____ days _____ number of bowel movements / day		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	* Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	* Where _____		
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (lower)	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (middle)	<input type="checkbox"/>	<input type="checkbox"/>	* Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (upper)	<input type="checkbox"/>	<input type="checkbox"/>	* Where _____		
Pain goes down the legs	<input type="checkbox"/>	<input type="checkbox"/>			
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Eye tiredness / strain	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Eye dryness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	<input type="checkbox"/>
Eyes feel swollen	<input type="checkbox"/>	<input type="checkbox"/>	Eye itchiness	<input type="checkbox"/>	<input type="checkbox"/>
Pressure in the eye	<input type="checkbox"/>	<input type="checkbox"/>	Eye tearing	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>			
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>

Bad taste in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in the tongue	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores / ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>
Changes in the skin color	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>
Skin bruising	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Presently</u>	<u>Had in</u>		<u>Presently</u>	<u>Had in</u>
	<u>Have</u>	<u>Past</u>		<u>Have</u>	<u>Past</u>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Skin acne	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Body hair changes	<input type="checkbox"/>	<input type="checkbox"/>			
Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Problems with alcohol or drug use	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychological crisis	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Psychoactive medications	<input type="checkbox"/>	<input type="checkbox"/>
Hot tempered	<input type="checkbox"/>	<input type="checkbox"/>	if yes which ones	<hr/>	
Stress	<input type="checkbox"/>	<input type="checkbox"/>	Emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
General chilliness	<input type="checkbox"/>	<input type="checkbox"/>	Shaking / tremors	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	Cysts / tumors	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Edema / water detention	<input type="checkbox"/>	<input type="checkbox"/>
General warmth	<input type="checkbox"/>	<input type="checkbox"/>	Night sweating	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory	<input type="checkbox"/>	<input type="checkbox"/>			

Smoking: How much per day? _____

Alcohol: How much per day? _____

Nutrition

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Exercise

What is your daily activity level related to your occupation:

- Sedentary i.e mostly sitting
- somewhat active
- moderately active
- very active (moving around or up most of the time)
- heavy duty (lifting, moving thingd etc.)

What kind of physical activity level (exercise, sports) do you participate in. How often per week? How long each time?

Miscellaneous:

How much water do you drink per day? _____

How many caffeine containing products (coffee, tea, carbonated pop) do you drink per day? _____

Snacks : _____

Male patients:

Please fill out the following section

Please check any conditions or symptoms that you presently have or had in the past

	Presently Have	Had in Past		Presently Have	Had in Past
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>

Female patients Please fill the

following section

Pregnancy: Are you presently pregnant? Y N Not sure

Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), abortions (A), whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

Year

Menstruation

Age of onset _____ Last Menstrual Period (first day of) _____ Date of last Pap exam ___/___/___

Result _____ Length between periods _____

Regularity:

regular irregular usually early by ___ days usually late by ___ days varies between being early or late

How many days of menstrual flow do you usually have?: _____

Flow is: even uneven heavy light
Color is pale pink light red red deep red purplish brown
Consistency is : thin thick clotted

Discomfort with period:

lower abdominal distention before during after menstruation
 lower back soreness before during after menstruation
 cramping before during after menstruation
 Other _____

Premenstrual Syndrome (PMS)

irritability bloating mood swings breast tenderness
 other _____

Vaginal Discharge

No Yes If yes, color and amount: _____

Menopause:

Age of onset _____ Any difficulties / symptoms? _____

Uterine bleeding (not related to periods) Color _____ amount _____
 comes on suddenly all the time
