HEALTH HISTORY Melanie L. Kaplan L,Ac. MTOM

Confidential Patient Information

DATE:_____________________

NAME:____

Date of Birth________________ Sex: M F Marital Status: S M D W P

Height:_______ Weight:__________ Social Security No.:______________________

Phone No. Home:______________________ Work:__________________________

Address:____

City:_______________________________ State:_____ Zip:______________________

May we contact you via E-mail? Y N Email:________________________________

Occupation/Profession____

Employer:____

Place of Birth:____

Emergency Contact:_______________ Tel:______________ Relationship__________

Referred by:____

Primary Care Physician:________________________ Tel:_______________________

Please List the MAIN concern that brought you in today, followed by additional complaints. Please indicate the dates first noticed.

1.____

2.____

3.____

4.____

Have you been diagnosed for this problem? If so what was diagnosis?_________

____

Name of Physician who made diagnosis:_______________________________________

How have you been treating condition until now?_____________________________

To what extent does the problem interfere with your activities of daily living (sleep, work, exercise, etc) ____

Do you have any contagious diseases presently?__________ If so what?_________

____

Please list past surgeries and year performed:

Please list Hospitalizations or significant traumas (car or sporting accidents) and year:

Please describe other traumas (death of a loved one, divorce, etc.) and year:

Please list any serious illnesses you have had, including childhood, and list year:

Please list any chronic illness, aches or pains which come and go:

List one or two emotions which are predominant in your life, and which you can either express easily or have difficulty expressing. (fear, grief, frustration, worry, joy, etc.)

Please describe a typical day's diet, with beverages:
Breakfast:

Lunch:

Dinner:

Most recent physical exam:____

Past Medical History (please indicate if you or a family member has any of the below by circling):

Heart Disease	Cancer
High Blood Pressure	Autoimmune Disorders
High Cholesterol	Fibromyalgia
Cardiac Pacemaker/Defibrillator	Epstein Barr Virus (EBV)
Hepatitis A, B, C	Lupus Erythmatosis (SLE)
HIV/AIDS	Anemia
Tuberculosis	Blood/Bleeding Disorder
STD's	Genital Herpes
Congenital Disorders	Cold Sores
Benign Tumors or Growths	Rheumatoid Arthritis
Epilepsy/Seizures	Surgical Implants
Kidney Disease	Stroke
Head Trauma	Warts, Plantar, HPV
Osteoarthitis	Infertility/Miscarriage
Migraines	Diabetes
Addiction	Mental Illness

Please circle what flavor you most often crave: Sour Bitter Sweet Spicy Salty

Are you on any specific eating plan or diet at the present time? If so what?

____

Please list a few of your favorite foods;________________________________

Do you exercise regularly? If so, what type?______________________________

____

Are you happy with your current body weight?_____________________________

Do you have a prefer: Room temperature drinks Cold Drinks Warm/Hot Drinks

Number of bowel movements each day:___________________________________

Are bowel movements: (circle) sticky dry well-formed pebbles

alternating constipation/diarrhea

How many hours of sleep do you get a night?_______________________________

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Upon waking do you feel rested?________ Do you have enough energy throughout the day?_________ What time of day is your energy the highest?______ the lowest?_________________

Please list any sleep concerns:

____

Are you sexually active?______________

FOR FEMALE PATIENTS ONLY:

Date of last menstrual period:______________ Is your cycle regular?______________

# of days between cycle:_______ Are you or may you be pregnant now?______

Age menses Began_____

Color of menstrual blood (bright red, dark red, brown, purple):

____

Consistency of menstrual blood (thick, watery, sticky, clotted, normal):___________

____

Do you have any undesirable menstrual symptoms? Please indicate if they are present prior, during or after the onset of menses:

☐Breast Pain/Distention ☐Back Pain ☐Irritability

☐Cramps ☐Bloating

☐Headache ☐Melancholy

Food Cravings (list foods):____

Do you have any of the following

☐Painful Periods(dysmenorrhea)

☐Fibroids

☐Breast Lumps

☐Endometriosis

Are you currently trying to conceive?________ For how long?____________________

Are you undergoing fertility treatment?___________ Birth Control?_______________

Please list # of Pregnancies:__________ #of live births___________________________

Date of last Gynecological Exam:_______________________

Please circle all that apply and provide additional information:

Do you use any of the following:

Alcohol # of drinks a day________ Type________________________________

Tobacco Packs a day____________ #of years using_____________________

Drugs Times a day/week________ Type________________________________

Coffee Cups a day_______________

Artificial sweetener Packs a day_________ Type__________________________

Soft Drinks # a day____________ Type________________________________

Please list all Medications, Dietary, or Vitamin Supplements you are currently taking, listing also the reason for taking and for how long.

1.____

2.____

3.____

4.____

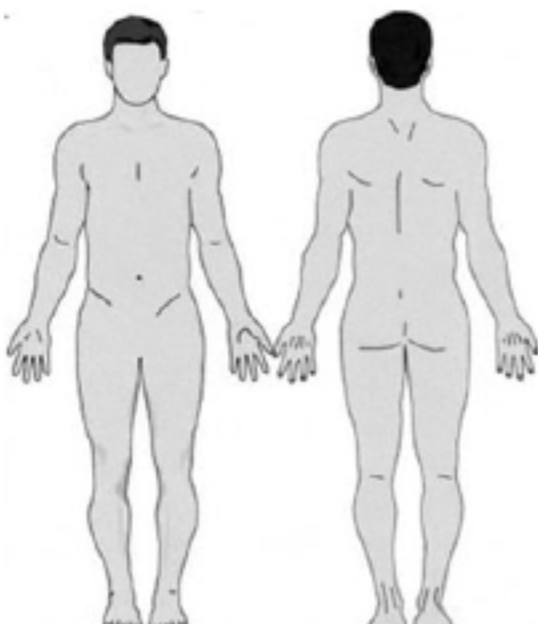
5.____

6.____

7.____

Please list all allergies or sensitivities (drugs, chemicals, foods, environmental, etc.)____

Use an 'x' to mark areas of current discomfort, and arrows to show radiation.



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Water Element:
☐Hearing loss
☐Dizziness
☐Low back pain/neck pain
☐Sinus congestion
☐Edema
☐Emotional instability
☐Aversion to cold
☐Hair thinning or loss
☐Premature Aging
☐Frequent Urination
☐Kidney Stones
☐Perspire Easily
☐Weak legs or knees
☐Asthmatic cough
☐Rapid weight loss
☐Loose teeth
☐Reduced sexual energy
☐Thyroid problems
☐Diabetes

Wood Element
☐Headache (tension)
☐Migraine
☐Ringing in ears
☐Poor eyesight
☐Eye infections
☐Eczema
☐Shingles
☐Herpes simplex
☐Warts
☐Nervousness
☐Convulsions, spasms
☐Irritability
☐Constipation
☐Ulcer
☐Vomiting
☐Gallstones
☐Indecisive
☐Fullness below ribs
☐Insomnia 11pm-3am
☐Shoulder/Neck tension

Fire Element:
☐Dry Scalp
☐Skin Eruptions
☐Cysts, tumors
☐Ear infections
☐Sore throat.tonsillitis
☐Lymphatic swelling
☐Hot palms Soles
☐Heart Palpitations
☐Aversion to heat
☐Bitter taste in the mouth
☐Gum Problems
☐Nose bleeds
☐Facial redness
☐Itchy/burning skin
☐Hot hands/feet
☐Vivid dreaming
☐Thirst
☐Dark urine
☐Night sweats

Earth Element:
☐Indigestion/ heartburn
☐Flatulence
☐Food allergies
☐Stomach pain/ulcer
☐Diarrhea
☐Halitosis
☐Strong appetite
☐Weak appetite
☐Nausea
☐Abdominal bloating
☐Low body weight
☐Hemorrhoids
☐Mouth sores

Metal Element
Bronchitis
Asthma
Shallow breathing
Cough
Sinus congestion
Nasal infection

Other (KD/UB)
☐Sciatic/nerve pain
☐Cold hands/feet
☐Tendonitis
☐Bursitis

Male:
☐Hernias
☐Testicular masses or pain
☐Prostate disease
☐Impotence
☐Frequent urination