

Confidential Medical History: Women, Page 1

Date _____.

Name _____ Age _____ Birth Date _____.

Address: _____.

City, State, Zip: _____ E-mail: _____.

Preferred Phone: _____ Other Phone: _____.

Primary Care Doctor _____.

Emerg Contact Name: _____ Tel: _____ Relationship: _____.

Why are you here today? _____.

_____.

Check if you have ever had any of the following problems:

- | | |
|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Kidney/Bladder infection |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies/ Sinus |
| <input type="checkbox"/> Blood clots in legs or lungs | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Breast problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Depression/psychiatric |
| <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Bone/muscle problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Artificial joints, heart valve, pacemaker |
| <input type="checkbox"/> Blood in stool/urine | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Stomach/intestinal problems | <input type="checkbox"/> NONE of the above |

Surgeries, Injuries, and Hospitalizations (please include dates):

_____.

Medications, herbs, supplements:

NAME	DOSE	REASON USED
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications:

_____.

Family History: Have any of your close relatives had serious medical problems?

_____.

Pregnancies

Year	Outcome
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_____	_____
_____	_____
_____	_____
_____	_____

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Gynecologic History:

Date of last pap smear _____ Mammogram _____
Have you had an abnormal pap smear? []yes []no
First Day of Last Period (or age of menopause) _____
Problems with menses? _____

Social History:

What is your occupation? _____
Do you use tobacco? []yes []no What kind? _____ How much? _____
How much alcohol do you drink? _____
Do you use recreational drugs? []yes []no
Do you have a regular exercise program? []yes []no
Are you on a modified or unusual diet? []yes []no
Marital status: [] Single [] Married [] Widowed [] Divorced [] Separated
[] Domestic Partnered [] Other
Birth control? _____
Do you want to become pregnant? []yes []no
Have you been exposed to sexual or physical violence or abuse? []yes []no
Are there other issues you would like to discuss? _____

Previous experience with acupuncture? _____

revised 9/07