Oriental Medicine Questionnaire

Date: _____
Name: _____ DOB _____ Sex: M F SS#_____
Address: _____ City _____ State____ Zip _____
Cell Phone: _____ Home Phone: _____ Business Phone _____
Occupation: _____ Height: _____ Weight: _____

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

Year	Illness	Treatment/ medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

Year	Surgery	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injuries / trauma

Year	Injury / Trauma	Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

Changes in the skin color	_____	_____	Dandruff	_____	_____
Skin bruising	_____	_____	Eczema	_____	_____
	Presently Have	Had in Past		Presently Have	Had in Past
Skin rashes	_____	_____	Psoriasis	_____	_____
Skin acne	_____	_____	Skin ulcerations	_____	_____
Body hair changes	_____	_____			
Sudden weight loss	_____	_____	Sudden weight gain	_____	_____
Diabetes	_____	_____	Thyroid disorder	_____	_____
Anxiety	_____	_____	Problems with alcohol or drug use	_____	_____
Depression	_____	_____	Psychological crisis	_____	_____
Irritability	_____	_____	Psychoactive medications	_____	_____
Hot tempered	_____	_____	if yes which ones _____		
Stress	_____	_____	Emotional difficulties	_____	_____
Fevers	_____	_____	Seizures	_____	_____
Chills	_____	_____	Concussion	_____	_____
Cold intolerance	_____	_____	Headache	_____	_____
General chilliness	_____	_____	Shaking / tremors	_____	_____
Cold hands / feet	_____	_____	Cysts / tumors	_____	_____
Heat intolerance	_____	_____	Edema / water detention	_____	_____
General warmth	_____	_____	Night sweating	_____	_____
Fatigue	_____	_____	Insomnia	_____	_____
Anemia	_____	_____	Nightmares	_____	_____
Poor memory	_____	_____			

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	_____	_____	Premature ejaculation	_____	
Prostatitis	_____	_____	Impotence	_____	_____

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 _____ usually late _____ varies between
by ____days by ____ days 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

Patient Informed Consent

I hereby voluntarily consent to be treated by acupuncture and or Chinese Herbs administered by Richard Blitstein, hereinafter referred to as "Practitioner". I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.

I acknowledge the fact that Richard Blitstein is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the Practitioner give any substances by injection.

Signature_____

Date_____

_____