yinfinite WELLNESS

10 El Camino Real, Suite 202 • San Carlos, CA 94070
T: 650.596.5616 • F: 650.596.5653 • www.yinfinitewellness.com

PATIENT HISTORY FORM

Today's Date__/____/20___ Patient ID #_____

Patient's Name_____D.O.B._____Referred by:_____

Chief Complaint: What is the main reason for your visit today? (Describe your problem)

_____

HISTORY OF PRESENT ILLNESS

Location of the problem_____
Which number best describes your problem on a scale of 1-10, with 10 being the most severe?_____
When did you first notice the problem? 2 days ago____2 weeks ago____1 month ago_____Other_____
How long does the problem last? 30 minutes_____ 1 hour____ It is always there_____ Other_____
Do you have any allergies to medications and/or supplements? YES_____ NO_____ If yes, please explain:
_____
_____
Do you have any environmental or food allergies? If yes, please explain:_____
_____
Please list all medications, supplements or herbs:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please give the date of your last visit to a medical doctor, i.e. family practitioner, OB/GYN, internal medicine, other specialty._____ Presenting problem?_____

List prior surgeries, or hospitalizations
Type_____Year_____
Type_____Year_____

Do you personally have a medical history of any of the following?
Heart disease___Hepatitis____High blood pressure____ Gout_____Cancer_____Ulcer disease_____
Mitral valve prolapse_____Strokes_____Diabetes_____Kidney Stones_____Glaucoma_____
Hypothyroidism_____High Cholesterol_____Parkinson's_____Seizures_____ Rheumatic Fever___
Infectious disease (HIV, Herpes)_____Other_____

List any major diseases or health problems in your family—include relationship (parents, siblings etc)

_____ _____
_____ _____

How do you feel about you? (Please check one box for each of the five aspects of your life.)

	GREAT	GOOD	OK	POOR	BAD	OTHER
FAMILY						
LOVE						
SEX						
SELF						
WORK						

Have you had acupuncture before? Yes_____No_____ If yes, please give the name/names & addresses of those practitioners_____

Dietary Habits

Do you drink alcohol? YES NO If yes, how much?_____
Do you drink coffee, tea, soda? YES NO If yes, which product and how much?_____
Do you smoke? YES NO Quit ___ years. If yes, how many/days/weeks, and how many years?_____

Lifestyle

Do you have trouble falling asleep or staying asleep?_____
Are you often tired or lethargic? YES NO
Is your libido satisfactory? YES NO

Review of Systems

Do you have any problems related to the following systems? Circle YES or NO

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other_____

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other_____

Ears, Nose, Throat, Mouth
- Hearing Loss Y N
- Nose Bleeds Y N
- Sore Throat Y N
- Dentures Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/Tingling Y N
- Other_____

Psychiatric
- Depression Y N
- Drug Addiction Y N
- Anxiety Y N
- Other_____

Endocrine
- Excessive Thirst Y N
- Too Hot/Cold Y N
- Tired/Sluggish Y N
- Other_____

Gastrointestinal
- Abdominal Pain Y N
- Irritable Bowel Y N
- Nausea/Vomiting Y N
- Indigestion Y N
- Other_____

Other: (Please Explain)
_____
_____
_____
_____
_____
_____
_____

Cardiovascular
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other_____

Musculoskeletal
- Joint Pain Y N
- Neck or Head Pain Y N
- Back Pain Y N
- Other_____

Integumentary (skin or breast)
- Rashes Y N
- Birthmarks Y N
- Lumps in breast/nipple Y N
- Other_____

Genitourinary
- Urinary Tract Infection Y N
- Yeast Infections Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent Cough Y N
- Shortness of Breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen Glands Y N
- Blood Clotting Problem Y N
- Other_____

Allergic/Immunologic
- HIV/AIDS Y N
- Eczema Y N
- Hives/Itching Y N
- Other_____

Females Only
- Birth Control Y N
- PMS Y N
- Date of Last Menses_____
- Cycle length _____ Ovulation Day_____

Gynecologic Surgery Y N
Explain_____
_____