명문한의학회 Myung Mun Oriental Medicine LLC
Fairfax Medical Center B/D 10721 Main Street Suite G7 Fairfax VA 22030, Tel. 703.865.7582 E-mail:acupuncturechoi@gmail.com

Comprehensive Health History Form

Patient Information

Name_____Date_____.

Address_____ City_____State_____Zip_____

Cell _____Work phone_____Home phone_____.

E-mail_____Have you had acupuncture before?( )Yes ( )No

Height_____Weight_____Age_____ Sex: ( )Male ( )Female Date of birth_____.

Occupation _____.

In emergency notify(name):_____Emergency phone number:_____.

Marital Status: ( )Single ( )Married ( )Other

Number of children:_____Ages of children:_____.

Primary Care Doctor_____Last seen:_____.

How did you hear about NFA clinic of Oriental Medicine: ( )A Talk ( )Article ( )Yellow Pages ( )Brochure

( )Business Card ( )Web site ( )Newspaper ( )Referred by:_____.

Insurance

Insurance Name_____ Insurance Group Number_____.

PrimaryInsured Name_____Primary ID Number_____.

PrimaryInsured DOB_____. Patient's relationship to Primary Insured: Self / Spouse / Child / Other

(Car accident) •Date: _____•Claim No:_____

•Insurance company:_____

.Medical History

Reason for your visit here today:_____

Are you being treated for this condition by anyone else: ( )Yes ( )No

If Yes, who?_____Phone number:_____.

Has this condition been diagnosed by a MD? ( )Yes (Diagnosis:_____) No( )

Have these treatments helped? ( )Yes ( )Somewhat ( )Not much ( )Not at all

How does this condition affect you?_____How long have you had this condition?

Do you currently have any infectious diseases? ( )Yes ( )No ( )Possibly

If Yes, please identify: ( )HIV+ ( )Hepatitis B ( )Hepatitis C ( )Flu/Cold ( )Streptococcus ( )Mononucleosis

( )Tuberculosis ( )Other:_____.

Known or suspected allergies:_____.

Childhood diseases you have had: ( )Chicken Pox ( )Measles ( )Mumps ( )Rheumatic Fever ( )Diphtheria

( )Scarlet Fever ( )Other:_____.

Physical or Emotional Traumas / Accidents / Hospitalizations / Surgeries in the past 10 years:

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Reason _____ Date/Year(s)_____.

Health Inventory

Cardiovascular Conditions:	**Emotional / Mental:**	**Energy & Immunity:**	**Respiratory:**
( ) **A Pacemaker**	( ) Clinical Depression	( ) **Metal Allergy**	( ) Pneumonia
( ) Heart Disease	( ) Mild Depression	( ) Chronic Fatigue Syndrome	( ) Asthma
( ) High Blood Pressure	( ) ADD or ADHD	( ) General Fatigue	( ) Frequent Common Colds
( ) Low Blood Pressure	( ) Schizophrenia	( ) Slow Wound Healing	( ) Difficulty Breathing
( ) Chest Pain	( ) Mood Swings	( ) Easy Bruising	( ) Emphysema
( ) Palpitation	( ) Panic Attacks	( ) Chronic Infections	( ) Persistent Cough
( ) Stroke	( ) Nervousness	( ) Frequent Allergies	( ) Pleurisy
( ) Varicose Veins	( ) Anxiety	( ) Shingles/Herpes zoster	( ) Tuberculosis
( ) Edema	( ) Alzheimer's		( ) Shortness of Breath
( ) Cholesterol	( ) Dementia		( ) Coughing
Musculo-Skeletal:	**Head, Eye, Ear, Nose & Throat:**	**Genito-Urinary Tract:**	**Gastrointestinal:**
( ) Neck Pain	( ) Impaired Vision	( ) Kidney Disease	( ) Stomach Ulcers
( ) Shoulder L / R	( ) Eye Pain/Strain	( ) Kidney Stones	( ) Changes in Appetite
( ) Muscle Spasms / Cramps	( ) Glaucoma	( ) Painful Urination	( ) Nausea / Vomiting
( ) Arm, Wrist Pain L / R	( ) Glasses / Contacts	( ) Dribbling Urination	( ) Epigastric / Abdominal Pain
( ) Upper Back Pain	( ) Tearing / Dryness	( ) Frequent UTI	( ) Passing Gas
( ) Low Back Pain	( ) Impaired Hearing	( ) Frequent Urination	( ) Heart Burn
( )Sciatic Neuralgia(Hipgout)	( ) Ear Ringing	( ) Blood in Urine	( ) Esophageal Reflux
( ) Herniated Disk	( ) Earaches	( ) Discharge	( ) Indigestion
( ) Hip Bone Pain	( ) Ear Infections	( ) Incontinence	( ) Belching
( ) Leg Pain L/ R	( ) Headaches, ( )Migraine		( ) Gall Bladder Disease
( ) Osteoporosis	( ) Sinus Problems	**Neurological:**	( ) Gall Bladder Stones
( ) Arthritis	( ) Nose Bleeds	( ) Vertigo / Dizziness	( ) Hemorrhoids
( ) Joint Pain	( ) Teeth Grinding	( ) Paralysis	( ) Constipation
( ) Rheumatoid Arthritis	( ) Frequent Sore Throats	( ) Numbness / Tingling	( ) Diarrhea
( ) Facial Paralysis	( ) TMJ / Jaw Problems	( ) Loss of Balance	
( ) Ankle(sprain)	( ) Hay Fever	( ) Seizures / Epilepsy	
		( ) Dyslexia	
Endocrine:	**Other:**	**Liver Conditions:**	**Men Only:**
( ) Hyperthyroid	( ) Cancer Type:_____.	( ) Hepatitis A	( ) Impotence
( ) Hypothyroid	( ) Fibromyalgia	( ) Hepatitis B	( ) Vasectomy Date:_____.
( ) Diabetes Type I	( ) Lupus	( ) Hepatitis C	( ) Prostate problems
( ) Diabetes Type II	( ) Candida	( ) Cirrhosis of Liver	( ) Testicular Pain / Redness / Swelling
( ) Hypoglycemia	( ) Anemia		( ) Low libido
( ) Night Sweats	( ) Rashes		( ) Excessive libido
( ) Unusual Sweating	( ) Eczema / Hives		( ) Painful Intercourse
( ) **Feeling Hot**	( ) Atopic Dermatitis		( ) Seminal emissions
( ) **Feeling Cold**	( ) Hemophilia		
( ) **Cold Hand / Feet**			

Women Only:

Are you **pregnant** right now? ( )Yes ( )No ( )Trying ( )Maybe Method of Birth Control:_____.
Age of first period:_____ Date of last menses:_____ Age of menopause:_____.
Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses):_____.
Number of Pregnancies:_____ Births:_____ Abortions:_____Miscarriages:_____.
Hysterectomy: ( ) Yes ( ) No If yes, date: _____.
Check all that apply: ( )Low libido ( )Excessive libido ( )Painful Intercourse ( )Clotting ( )**Painful Periods**
( )Heavy Flow ( )Scanty Flow ( )Bleeding Between Cycles ( )**Irregular Cycles** ( )Vaginal Discharge
( )Breast Lumps/Tenderness ( )Nipple Discharge ( )**Infertility** ( )**Menopausal Symptoms** ( )Premenstrual Problems

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Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ( )Yes ( )No Amount:_____ Alcohol: ( )Yes ( )No Amount: _____.

Coffee: ( )Yes ( )No Amount:_____ Recreational Drug: ( )Yes ( )No Amount:_____.

Do you feel you are at or near your ideal weight? ( )Yes ( )No

Do you feel you have enough energy? ( )Yes ( )No Are you vegeterian or vegan? ( )Yes ( )No

Best time of day(full of energy):_____ Worst time of day(least energy):_____.

Favorite Season: _____ Hours of sleep / night: _____.

Do you feel rested after a night sleep?_____ Do you remember your dreams?_____.

Typical day's meals:

Breakfast:_____.

Lunch: _____.

Dinner:_____.

Snacks / Other:_____.

Food cravings: _____.

Religion or other spiritual practice:_____.

Hobbies or other recreation: _____.

What kind of physical exercise do you do regularly?_____.

Hours of work per week?_____.

How would you rate your current stress level? ( )Extreme ( )Very High ( )High ( )Moderate ( )Low

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

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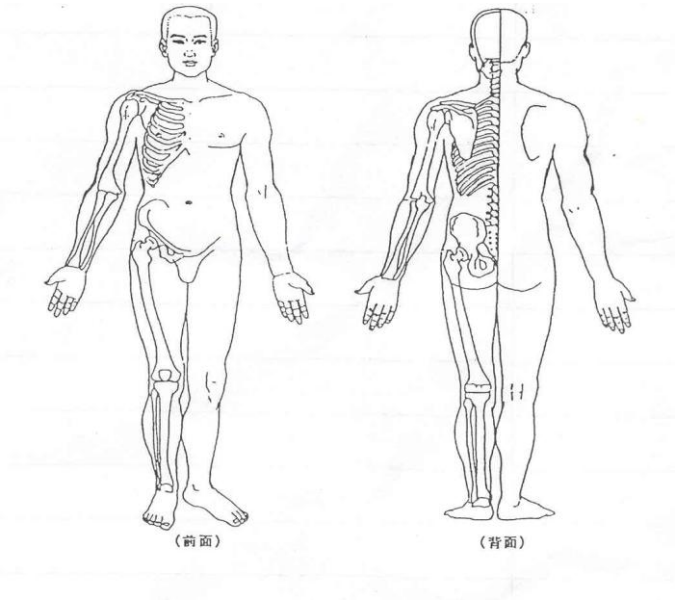
Use the diagram if desired.

How bad is your pain?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Unbearable pain



The Above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify NFA Clinic of Oriental Medicine 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed:_____Date:_____.

Parent / Guardian (if applicable)_____.

Would you like to receive a free email newsletter: ( )Yes ( )No