ITORYE SILVER ACUPUNCTURE
PATIENT MEDICAL HISTORY

Please fill in ALL PAGES BEFORE YOUR APPOINTMENT. Your answers will help us plan and provide your care. Leave blank any parts you are unsure of, or do not wish to answer. Any information provided will be kept confidential.

CURRENT MEDICAL HISTORY

Do you have allergies? □ Yes □ No □ Not Sure / Don't know

If so, please list: ______________________________

Do you wear a cardiac pacemaker? □ Yes □ No □ Not Sure / Don't know

Family Medical History: Does any member of your family (parents & siblings) have any of the following?

Diabetes, Hypertension, Cardiovascular diseases, Autoimmune diseases
Cancer, Stroke, Seizures

If so, please describe: ______________________________

____

Occupation: ______________________________

Do you have a regular exercise program? □ Yes □ No
If so, please describe: ______________________________

Do you have any dietary restrictions? □ Yes □ No
If so, please describe: ______________________________

Please describe your average daily diet:

Morning Afternoon Evening

____

____

____

Do you smoke? □ Yes □ No, never smoked □ No, I have quit smoking
If yes, how many packs of cigarettes do you smoke a day? ______________________________

How much coffee, tea, or caffeinated beverage do you consume?
□ 1-2 cups per day □ 2-5 cups per day □ >5 cups per day □ occasional/social □ None

How much alcohol do you consume per week?
□ 1-2 glasses per day □ 2-5 glasses per day □ >5 glasses per day □ occasional/social □ None

Please describe any use of drugs for non-medical purposes: ______________________________

Patient Name: ______________________________ Date: ______________

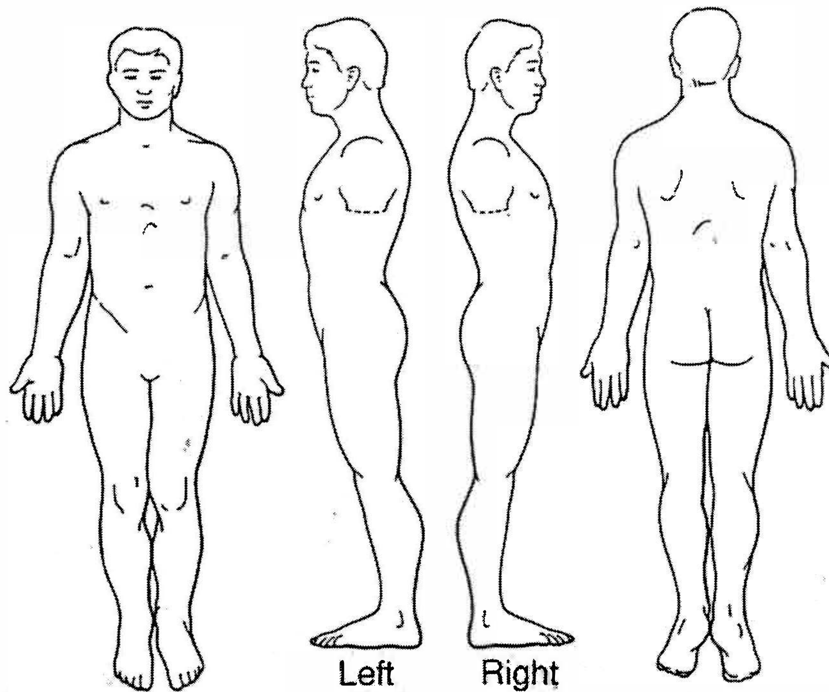
PAIN:

Do you have pain? ☐ Yes ☐ No

If so, please describe: ____

____

Please indicate affected and/or painful area(s)



Worst Possible Pain (Dolor severo)

10
9
8
7
6

Moderate Pain (Dolor moderado)

5
4
3
2
1

No Pain (No dolor)

0

Pain	
x	Little
xx	Moderate
xxx	strong

FATIGUE:

Do you feel fatigued? ☐ Yes ☐ No

If so, please describe: ____

____

NO FATIGUE	MILD	MODERATE	EXTREME	THE WORST FATIGUE
0	1 2 3	4 5 6	7 8 9	10

Patient Name: ______________________ Date: ______________

Women only:

Are you pregnant now? ☐ Yes ☐ No

Number of pregnancies:__________ Number of children:__________

Age of first period:__________ Age of menopause:__________

Is your menstrual cycle regular? ☐ Yes ☐ No ☐ Post-menopausal

1. Average number of days in flow:________
2. Volume: ☐ Normal ☐ Heavy ☐ Light
3. Color: ☐ Normal ☐ Dark red ☐ Purple ☐ Light brown
4. Do you have the following menstruation related signs/symptoms?

   ☐ Blood clots ☐ Cramps ☐ Nausea ☐ Breast distension

   ☐ Mood changes ☐ Bleeding/spotting between periods

   ☐ Heavy vaginal discharge between periods

Do you use any contraception? ☐ Yes ☐ No ☐ Not applicable

If Yes, please describe:____________________________________

Libido (sex drive) is:

☐ Low ☐ Normal ☐ High

Men Only

Do you experience any of the following? (*please check all that applies)*

☐ Feeling coldness or numbness in the external genitalia ☐ Pain or swelling in testicles

☐ Premature ejaculation ☐ Impotence/ erectile dysfunction

Libido (sex drive) is:

☐ Low ☐ Normal ☐ High

MEDICATIONS

Please list all the medications you are currently taking, including all vitamins and supplements

Name of medication	Dose	Frequency

Patient Name: ____________________ Date: ______________

REVIEW OF SYSTEMS *Put a check mark by the symptom(s) that you are currently experiencing:*

Constitutional Symptoms
___ Fatigue / low energy
___ Poor appetite
___ Insomnia / poor sleep
___ Fever or chills
___ Night sweats
___ Heat sensation or hot flashes
___ Unexplained weight loss or weight gain
Other: ___________________________

Allergy / Immunological
___ Hay Fever
___ Other: ___________________________

Ear / Nose / Throat / Oral
___ Ear Infection
___ Hearing loss
___ Sinus problems
___ Sore throat
___ Oral (canker) sores
___ Bleeding, swollen painful gums
___ Halithosis (bad breath)
Other: ___________________________

Eyes / Vision
___ Blurred / double vision
___ Eye pain
___Dryness / irritation
Other: ___________________________

Gastrointestinal
___ Heart burn
___ Nausea / vomiting
___ Abdominal pain / cramps
___ Diarrhea
___ Constipation
___ Palpitations
___ Bleeding from rectum
___ Black sticky stools
___ Hemorrhoids
___ Change in bowel habits
Other: ___________________________

Respiratory
___ Chronic cough
___ Chest congestion
___ Difficulty breathing / shortness of breath
___ Recurrent chest infection
___ Asthma / wheezing
Other: ___________________________

Cardiovascular
___ Chest pain
___ High blood pressure
___ Palpitations
___ Edema / swelling
Other: ___________________________

Neurological
___ Headaches
___ Dizziness / fainting
___ Numbness / tingling
___ Tremors
___ Seizures / epilepsy
Other: ___________________________

Musculoskeletal
___ Joint pain / stiffness / swelling
___ Neck pain / stiffness
___ Back pain / stiffness
___ Muscle weakness
Other: ___________________________

Endocrine
___ Excessive thirst
___ Feeling too hot / too cold
___ Diabetes
Other: ___________________________

Urinary
___ Blood in urine
___ Bladder / kidney infection
___ Problem with urination
___ Bladder / kidney stones
Other: ___________________________

Hematological / Lymphatic
___ Easy bruising
___ Swollen glands
___ Excessive bleeding
___ Blood clotting problems
Other: ___________________________

Skin / Dermatological
___ Skin rash
___ Persistent itch
Other: ___________________________

Gynecological
___ Abnormal / irregular bleeding
___ Abnormal vaginal discharge
___ Hot flashes
___ Breast lump, pain or discharge
___ Hot flashes
Other: ___________________________

Psychological
___ Feeling sad or depressed
___ Worried / anxious
Other: ___________________________

Patient Name: ___________________________ Date: ___________________