New Health Chinese Medicine Center

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http://www.chinesemedicinecenter.com

INFORMAITON REQUIRED FOR CASE HISTORY

CHART NUMBER_____ DATE_____

PATIENT NAME_____Sex_____
(Mr./Mrs./Miss) First Name Middle Initial Last Name

DOB _____Age _____Occupation _____SSN #_____

Home Address_____

Home Phone _____Cellular Phone _____Business Phone_____

Guardian Name for Underage_____

Please answer each question

History of Present Illness

Chief Complaint: _____
_____

What medicine, if any, are you taking now? **YES ☐ NO ☐**
_____
_____

Are you pregnant now? **YES ☐ NO ☐**
Feeling—Anxiety, Depression or Hallucination? **YES ☐ NO ☐**

Past Medical History

Are you now or have you been under the care of a physician during the past two years? **YES ☐ NO ☐**
Are you subject to profuse bleeding? **YES ☐ NO ☐**
Are you subject to any nervous disorder, fainting or dizziness? **YES ☐ NO ☐**
Are you sensitive or allergic to any drug? **YES ☐ NO ☐**
If yes, specify the medicine? _____
Have you had heart trouble or high blood pressure? **YES ☐ NO ☐**
Have you had rheumatics fever? **YES ☐ NO ☐**
Have you had diabetes? **YES ☐ NO ☐**
Have you had asthma? **YES ☐ NO ☐**
Have you had tuberculosis? **YES ☐ NO ☐**
Have you had kidney, liver gallbladder, or stomach problem? **YES ☐ NO ☐**
Have you experienced any unfavorable reaction from any previous medical treatment? **YES ☐ NO ☐**
If yes, please provide detail? _____

Family History

Medical history of other family members_____

Permission is hereby granted for necessary Acupuncture and Herbs treatment.

Patient (Guardian) Signature_____ Date _____

Note