

## Patient Initial Medical/Physical Information

**Camy's Acupuncture & Herbs Clinic**

**Dr. Anca-Camelia Prunean, DOM, AP, L.Ac**

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**\*Filling Instruction: Please try your best to fill out the form below. If possible, please answer most questions with *Yes* or *No*. Thank you for your cooperation. All information is confidential. Total number of pages is 4.\***  
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**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Gender:** M \_\_\_ F \_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_\_\_(Month/Date/Year)

Home Address: Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip-Code: \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Number:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Emergency Contact: Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Contact Number:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Who referred you for this appointment?**

### **Medical History:**

**Major Complaints:** (Please list them in order of importance.)

1. \_\_\_\_\_ How Long \_\_\_\_\_

2. \_\_\_\_\_ How Long \_\_\_\_\_

3. \_\_\_\_\_ How Long \_\_\_\_\_

Other \_\_\_\_\_

**Personal History:**(Please check and list all diseases and surgeries for which you have had in the past.)

AIDs/HIV                      Alcoholism                      Antibiotic use                      Asthma

Bleed easily                      Chicken Pox                      Epilepsy                      Glaucoma

Heart Disease                      High Blood Pressure                      High Cholesterol                      High fevers

Jaundice                      Kidney Disease                      Measles                      Meningitis

Mental disorders                      Mumps                      Multiple Sclerosis                      Pacemaker

Pneumonia                      Polio                      Rheumatic fever                      Rheumatoid Arthritis

Scarlet fever                      Stroke                      Typhoid fever                      Tuberculosis

Vascular Diseases                      Venereal Diseases

Allergies. If yes, please list what you are allergic to: \_\_\_\_\_

Cancer. If yes, please list what cancer you have had: \_\_\_\_\_ On Chemo now \_\_\_\_\_

Diabetes: Type 1 \_\_\_ or Type 2 \_\_\_    Hepatitis: Type A \_\_\_ Type B \_\_\_ Type C \_\_\_ Other \_\_\_\_\_

Thyroid disorders: Hyperthyroidism \_\_\_ Hypothyroidism \_\_\_    Ulcers. If yes, where: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Other: \_\_\_\_\_

**Family History:** (Please check all illnesses which have occurred in any of your blood relatives.)

- Alcoholism                       Allergies                       Bleed easily                       Cancer  
 Diabetes                       Epilepsy                       High Blood Pressure                       High Cholesterol  
 Heart Disease                       Kidney Disease                       Mental illness                       Obesity  
 Stroke

Other: \_\_\_\_\_

**Medications / Supplements / Drugs**

**Prescription drugs** (Please list all medications you are currently taking.):

1. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
2. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
3. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
4. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
5. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
6. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_  
7. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ For \_\_\_\_\_

Others: \_\_\_\_\_

**Vitamins/Supplements** (Please list all you are currently taking.): \_\_\_\_\_

**Tobacco:** Yes \_\_\_ No \_\_\_ Amount: \_\_\_\_\_ In the past: \_\_\_\_\_

**Alcohol:** Yes \_\_\_ No \_\_\_ Amount: \_\_\_\_\_ In the past: \_\_\_\_\_

**Caffeine:** Yes \_\_\_ No \_\_\_ Amount: \_\_\_\_\_ In the past: \_\_\_\_\_

Notes: \_\_\_\_\_

**Body Temperature**

**General feeling** of Body Temperature: Hot \_\_\_ Cold \_\_\_ Neutral \_\_\_ Whole Body \_\_\_ Areas \_\_\_\_\_

**Perspiration:** More \_\_\_ Less \_\_\_ Spontaneous \_\_\_ Night \_\_\_ Odor: **Yes** \_\_\_ **No** \_\_\_ Other \_\_\_\_\_

Notes: \_\_\_\_\_

**Diet / Nutrition**

What do you eat: \_\_\_\_\_

What do you not eat: \_\_\_\_\_

Any food you are allergic to: \_\_\_\_\_

Appetite: Good \_\_\_ Strong \_\_\_ Low \_\_\_ Feel hungry at time of eating: Often **Yes** \_\_\_ **No** \_\_\_

How does food affect you after you eat: Energized \_\_\_ Tired \_\_\_ Gas \_\_\_ Bloating \_\_\_

Temperature preference of food & drink: Cold-side \_\_\_ Warm-side \_\_\_ Other \_\_\_\_\_

Total Daily Liquid Consumption: \_\_\_\_\_ Thirst level: High \_\_\_ Normal \_\_\_ Low \_\_\_

Cravings: \_\_\_\_\_ Any special **Taste** in mouth: **Yes** \_\_\_ **No** \_\_\_ What it is \_\_\_\_\_

Notes: \_\_\_\_\_

**Elimination**

**Urination:** Frequency: \_\_\_/Day \_\_\_/Night Color: \_\_\_\_\_ Dark \_\_\_ Light \_\_\_ Cloudy \_\_\_  
Urgent \_\_\_ Burning \_\_\_ Painful \_\_\_ Difficulty \_\_\_ Amount: Scanty \_\_\_ Profuse \_\_\_  
Notes: \_\_\_\_\_

**Stools:** Frequency: \_\_\_/Day Complete bowel movement \_\_\_ Difficulty \_\_\_ Undigested Food \_\_\_  
Consistency: Formed \_\_\_ Hard \_\_\_ Loose \_\_\_ Sticky \_\_\_ Alternating (normal, loose and hard) \_\_\_  
Smell: Normal \_\_\_ Strong/foul \_\_\_ Other: Blood \_\_\_ Dark red \_\_\_ Bright red \_\_\_ Mucous \_\_\_  
Notes: \_\_\_\_\_

**Sleep**

Hours per night: \_\_\_\_\_ Time to bed: \_\_\_\_\_ Time to wake: \_\_\_\_\_ Rested when wake up: \_\_\_  
Trouble falling asleep: \_\_\_ Racing mind \_\_\_ Trouble waking up: \_\_\_ Trouble staying asleep \_\_\_  
Waking at night: \_\_\_ Time \_\_\_\_\_ Trouble going back to sleep: \_\_\_\_\_  
Dreams: \_\_\_ Excessive \_\_\_ Vivid \_\_\_ Nightmares \_\_\_ Heart Palpitations: \_\_\_ How often \_\_\_\_\_  
Sweat during sleep: \_\_\_\_\_  
Notes: \_\_\_\_\_

**Energy**

Exercise: Type: \_\_\_\_\_ How often: \_\_\_\_\_  
Level of energy (Scale from 1 to 10): \_\_\_\_\_ Best time of day: \_\_\_\_\_ Worst time of day: \_\_\_\_\_  
Notes: \_\_\_\_\_

**Emotions**

At this time: \_\_\_\_\_ Stable \_\_\_\_\_  
Significant past emotional states if any: \_\_\_\_\_  
How would you describe your emotions as a child: \_\_\_\_\_  
Notes: \_\_\_\_\_

**Body System Review**

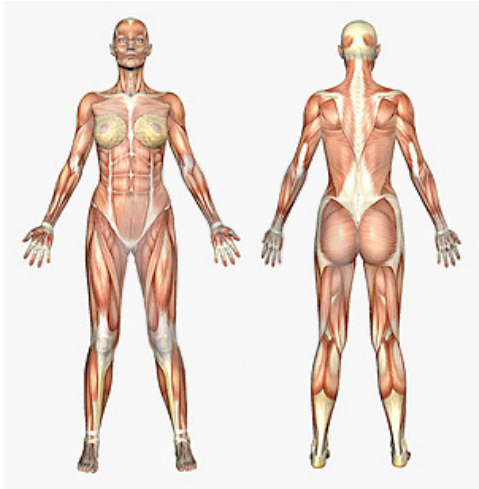
**Head:** Headache: Location \_\_\_\_\_ How often \_\_\_\_\_ Type of Pain \_\_\_\_\_  
Migraine: \_\_\_\_\_ Dizziness: \_\_\_\_\_ Foggy head \_\_\_\_\_ Heavy head \_\_\_\_\_  
**Eyes:** Red \_\_\_ Itchy \_\_\_ Watery \_\_\_ Blurry \_\_\_ Floaters \_\_\_ Grit (Discharge from eyes) \_\_\_  
Decreased Night Vision \_\_\_ Glasses or Contacts: \_\_\_ For: \_\_\_\_\_ How Long: \_\_\_\_\_  
**Ears:** Ringing: \_\_\_\_\_ Pitch: \_\_\_\_\_ Very Loud \_\_\_\_\_ Discharge: \_\_\_\_\_  
**Nose:** Congestion \_\_\_ Running \_\_\_ Discharge: Clear \_\_\_ Yellow \_\_\_ Bloody \_\_\_ Other \_\_\_\_\_  
**Gums:** Bleeding \_\_\_ Soreness \_\_\_ Other: \_\_\_\_\_ **Teeth:** Sensitive \_\_\_ Cavities \_\_\_ Loose \_\_\_  
**Throat:** Chronic sore throat \_\_\_\_\_ Swollen or sore glands \_\_\_\_\_ Trouble swallowing \_\_\_\_\_  
**Chest:** Pain \_\_\_ Oppression or heaviness in the chest: \_\_\_ Shortness of Breath \_\_\_ When: \_\_\_\_\_  
**Abdomen:** Pain: \_\_\_ Upper \_\_\_ Lower \_\_\_ Stomach \_\_\_ Acid-reflux \_\_\_ Heartburn \_\_\_  
Abdominal distension \_\_\_ Other \_\_\_\_\_

Notes: \_\_\_\_\_

**Joint & Muscle Pain**

**Joint pain:** Finger \_\_\_\_ Wrist \_\_\_\_ Elbow \_\_\_\_ Shoulder \_\_\_\_ Toe \_\_\_\_ Ankle \_\_\_\_ Knee \_\_\_\_ Hip \_\_\_\_

**Joint swelling:** \_\_\_\_\_



Arm pain \_\_\_\_ Leg pain \_\_\_\_ Neck/Shoulder Tension \_\_\_\_

Back pain: Upper \_\_\_\_ Middle \_\_\_\_ Lower \_\_\_\_ Sacrum \_\_\_\_

Numbness/tingling in body: \_\_\_\_\_

Specific Location (if any): \_\_\_\_\_

**Pain is:** Constant \_\_\_\_ Sharp \_\_\_\_ Dull \_\_\_\_ Fixed \_\_\_\_

Better with: Pressure \_\_\_\_ Heat \_\_\_\_ Cold \_\_\_\_ Rest \_\_\_\_

Movement \_\_\_\_ Treatments \_\_\_\_\_

Or Worse with: Pressure \_\_\_\_ Heat \_\_\_\_ Cold \_\_\_\_

Rest \_\_\_\_ Movement \_\_\_\_ Other \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Female Only**

**Menses:** Date of last: \_\_\_\_\_ Age at menarche: \_\_\_\_ #Days between cycle: \_\_\_\_\_

#Days of Flow: \_\_\_\_ Light \_\_\_\_ Medium \_\_\_\_ Heavy \_\_\_\_ Color: \_\_\_\_\_ Clots: \_\_\_\_\_

Pain or Cramps: \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After \_\_\_\_ Is it better with: Heat \_\_\_\_ Pressure \_\_\_\_

Breasts tenderness: \_\_\_\_ Irritable: \_\_\_\_ Fatigue: \_\_\_\_ Cravings: \_\_\_\_\_ Mood changes: \_\_\_\_\_

Ovulation pain: \_\_\_\_ Sexual energy: High \_\_\_\_ Average \_\_\_\_ Low \_\_\_\_ Birth control: \_\_\_\_ Since \_\_\_\_

**Pregnancies:** Now Pregnant: *Yes* \_\_\_\_ *No* \_\_\_\_ Pregnancies in the past \_\_\_\_ /Times Premature: \_\_\_\_\_

Full term: \_\_\_\_ Miscarriage: \_\_\_\_ Abortion: \_\_\_\_ Diseases during or after: \_\_\_\_\_

**Menopause:** *Yes* \_\_\_\_ *No* \_\_\_\_ Age at onset: \_\_\_\_ Hot Flashes: \_\_\_\_ Night sweat: \_\_\_\_ Other \_\_\_\_\_

**Vaginal:** Discharge: *Yes* \_\_\_\_ *No* \_\_\_\_ If yes, When: Daily \_\_\_\_ Around period \_\_\_\_ Other \_\_\_\_\_

Color: White \_\_\_\_ Yellow \_\_\_\_ Both \_\_\_\_ Sticky \_\_\_\_ Smell: \_\_\_\_\_ Vaginal dryness: \_\_\_\_\_

Yeast infection: *Yes* \_\_\_\_ *No* \_\_\_\_ If yes, Itchiness \_\_\_\_ Chronic \_\_\_\_\_ Other \_\_\_\_\_

**Sexual Diseases if any:** \_\_\_\_\_

Notes: \_\_\_\_\_

**Male Only**

Prostate: Normal \_\_\_\_ Enlarged \_\_\_\_ Unknown \_\_\_\_ Urination changes \_\_\_\_ Impotence: *Yes* \_\_\_\_ *No* \_\_\_\_

Premature ejaculation: *Yes* \_\_\_\_ *No* \_\_\_\_ Sexual energy: High \_\_\_\_ Average \_\_\_\_ Low \_\_\_\_

**Sexual Diseases if any:** \_\_\_\_\_

Notes: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_