Lotus Acupuncture
& Fertility Clinic

513 N Morrison Rd, Vancouver WA, 98664 | (360) 984-6489

Patient Health History

Name: _____ Visit Date: _____
(First) (Middle) (Last) (MM/DD/YY)

DOB: _____ Gender: __ Height: _____ Weight: _____ Blood Pressure _____

Marital Status: _____ Occupation: _____

Home Address: _____
(Street Number) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Please identify the health concerns that have brought you to the clinic (condition, onset, severity, treatment):

Chief Complaint: _____

Secondary Complaint: _____

Other Complaints_____

_____

2. What are your most important health problems? Please list in order of importance.

a. _____ b. _____

c. _____ d. _____

3. Please list any prescription medications and over-the-counter medications that you are currently taking (also indicate the purpose for medications):

1. _____ 2. _____

3. _____ 4. _____

4. Please list any foods, drugs, or medications you are hypersensitive or allergic to (also include the type of reaction)

_____

_____

_____

_____

5. Are you currently receiving health care? Y N
If yes, where and from whom?

_____

6. X-Rays/CAT Scans/MRI's/NMR's/Special Studies (Reason, When, Result):

_____

_____

7. Hospitalizations and Surgeries (Reason, Where, When):

_____

_____

8. Do you have any reason to believe that you are pregnant? Y N

9. Do you have any chronic infectious diseases? Y N If yes, please explain: _____

10. Are you currently suffering from any chronic illness? Y N If yes, please explain: _____

11. Family History of Diseases (please indicate paternal or maternal)

_____

_____

12: Do you generally feel warm_____, or cold _____ ?

13. Do you have perspiration day time _____, night _____?

14. Describe your energy condition _____

15. Describe your bowel movement, frequency, loose or constipation

_____

16. Describe your mental/emotional condition_____

17: Describe your sleep condition _____

18. Smoking: Yes__, No__ If yes, how much?_____

Alcohol: Yes__ , No__ If yes, how much? _____

Coffee: Yes___, No__ If yes, how much?_____

Drugs: Yes__, No___ If yes, how much? Which drug _____

19. Describe your diet _____

20. Describe your exercises_____

21. Is there anything else we should know?_____