Patient Intake Form

Name:		
Date of Birth:	Address:	Phone: Email:

Please list **SPECIAL PROBLEMS** you would like evaluated today in order of significance:

1.

2.

3.

4.

MEDICATION ALLERGIES: (such as penicillin):	**OTHER ALLERGIES**: (such as bees/wasps, foods, latex, etc):

MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and Non-Prescription
(including aspirin, vitamins, birth control, herbs, supplements, etc.)

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries in the past 5 years:

Office Use Only

Initials: Date:

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FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grand-parent	Other
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness						
Suicide						
Other health problems						

SOCIAL HISTORY

I'm **NOT** happy with (circle those that apply) →	Myself	My Health	My Work
	My Partner	My Life	My Home

Your Occupation:		
Favorite Hobby/Pass-time:		
Married?	Yes	No
In a Relationship?	Yes	No
Children?	Yes	No
Do your household support family members other than spouse/kids?	Yes	No
Recent Significant Changes in Your Life?	Yes	No
Family Relationship Hardships?	Yes	No
Financial Hardships?	Yes	No
Employmnt/Job Hardships?	Yes	No
Have Special Stresses in Your Life?	Yes	No
Smoke/Chew Tobacco?	Yes	No
Consume alcoholic beverages more than once a week?	Yes	No

CURRENT HEALTH PRACTICES

Do you exercise regularly?	Yes	No
Do you eat out often each week?	Yes	No
Are you happy with your weight?	Yes	No
Do you take any vitamins or supplement regularly?	Yes	No
Are you on any **special diet**?	Yes	No

Umai Health
Vienna Acupuncture

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REVIEW OF SYSTEMS:
Circle those items you **currently** have significant problems with or that apply:

GENERAL

Recent Weight Change	Increased Thirst or Urination	Night Sweats/Hot Flashes
Always Hot/Always Cold	Rashes or Skin Problems	Significant Fatigue
Chronic pain problems		

BREASTS: Men & Women

Lumps/Tenderness	Drainage from Nipple
Month /Year of Last Brest Exam (women):	

EYE, EAR, NOSE, AND THROAT

Glaucoma	Blurred or Double Vision- Ever	Glasses or Contact Problems
Hearing Loss	Brief Loss of Vision- Ever	Teeth or Gum Problems
Had Radiation Therapy to Head or Neck:		Yes_ No_

CARDIOPULMONARY

Shortness Of Breath With Activity	Dizziness	Chest Pain
Daily Sputum (Phlegm) Production	Coughing Up Blood	Heart Palpitations
Difficulty Breathing While Lying Flat	Leg Cramps While Walking	Wheezing
Waking Up Short of Breath	Daily Cough	Ankle Swelling

GASTROINTESTINAL

Change of Appetite	Abdominal Pain	Blood in Stool/Black Stool
Difficulty Swallowing	Diarrhea/Constipation	Frequent Nausea/Vomiting
Heartburn	Indigestion From Fatty Foods	

NEUROPSYCHIATRIC

Frequent Disabling Headaches	Difficulty Sleeping	Tremors
Frequent Anxiety or Anxiety Attacks	Memory Loss	Passing Out/Fainting
Treated for Emotional or Psychological Problems		Often Feel Sad or Depressed

MUSCULOSKELETAL & SKIN

Frequent Neck or Back Pain	Muscle Pain	Disabling Night Leg Cramps
Joint Problems	Use a Brace or a Splint	
Mole that has changed color, size, shape, or won't heal		

GENITOURINARY: MEN & WOMEN

Urinary Tract Infections	Sores in the Genital Area
Difficult or Painful Urination	Blood in Urine
History of Kidney or Bladder Stones	Urination More Than Once a Night
History of Four or More Sex Partners	Sexual Intercourse Before 18 years old
Method of Birth Control:	
Have you ever had any Sexually Transmitted Disease:	Yes_ No_

GENITOURINARY: MEN ONLY

Pain or Lump in Testicles/Scrotum	Do you do Self Testicular Exam: Yes_ No _

GENITOURINARY: WOMEN ONLY

Age of first Period	Menstrual Periods Problems
Menstrual Cramp Problems	Recent Change in Menstrual Pattern
Vaginal Discharge/Itching Problems	Ever Have Abnormal Pap Smear: Yes_ No_

Initials: Date:

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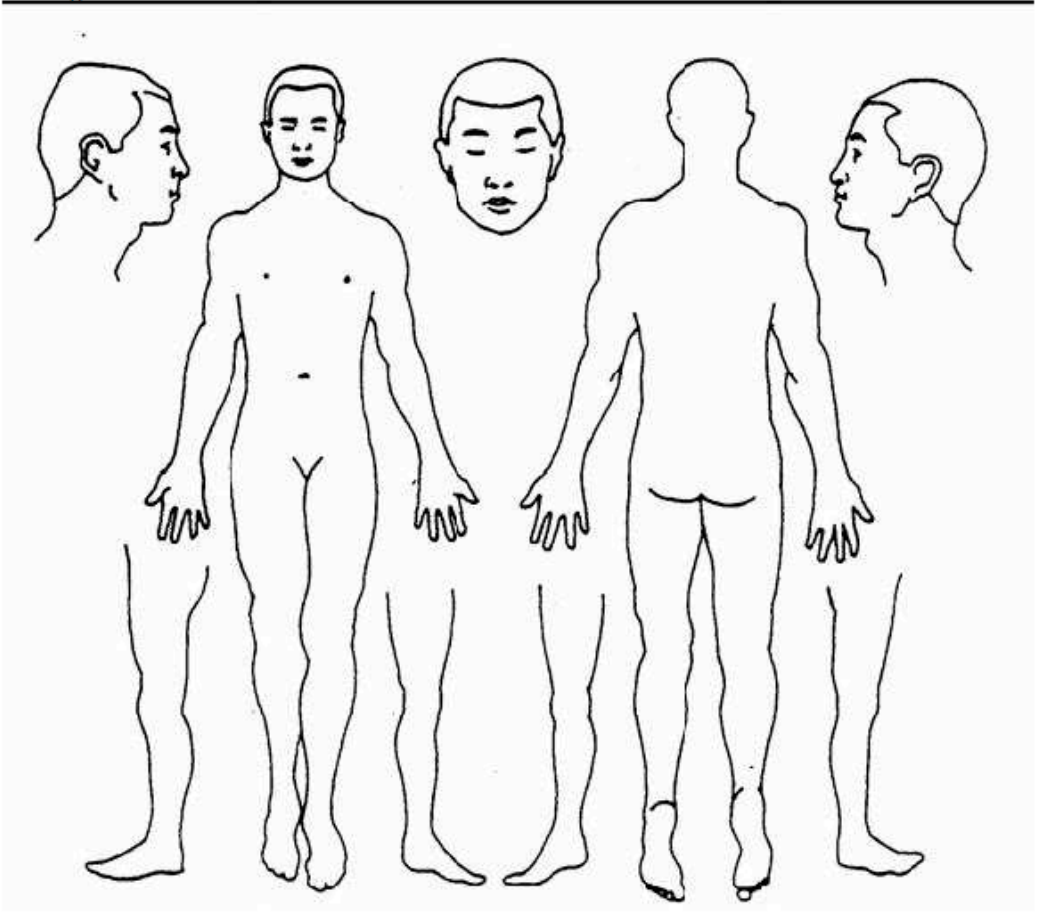
Please indicate on the picture below:
Pain & Tenderness = O
Numbness and Tingling = Z
Swelling and Stiffness = X



To the best of my knowledge, this is an accurate statement of my health:

Signature:_____ Date:_____

Initials: Date: