



# Patient Information

CONFIDENTIAL

Eastern Harmony Acupuncture & Herbal Clinic ■ 4611 Montrose Blvd, Suite A201 ■ Houston, TX 77006  
www.easternharmonyclinic.com

Phone: 713-529-1610 Fax: 713-529-6870

## Welcome to Eastern Harmony Acupuncture & Herbal Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Eastern Harmony Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)		DATE	
AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
PHONE (HOME)	PHONE (CELL)	PHONE (WORK)	
HOME ADDRESS			
CITY		STATE	ZIP
OCCUPATION		EMAIL ADDRESS	
EMPLOYED BY			
EMPLOYERS ADDRESS			
CITY		STATE	ZIP
REFERRED BY			
SPOUSE'S NAME			
CONTACT IN CASE OF AN EMERGENCY		RELATIONSHIP	PHONE
ADDITIONAL INFORMATION/NOTES			

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Eastern Harmony Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



# Medical History

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MAJOR COMPLAINT/HEALTH PROBLEM

.....

.....

HOW DID THIS CONDITION DEVELOP?

.....

.....

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN?
---	---------------

WHERE?	BY WHOM?
--------	----------

WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
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WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	PROBLEM/SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

.....

.....

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	

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*Please check any symptoms you currently have or have had in the past year.*

**General**

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

**Head & Neck**

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision – see halos

**Respiratory**

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production

- Difficulty inhaling
- Difficulty exhaling

**Cardiovascular**

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

**Gastrointestinal**

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Poor appetite
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

**Diet/Lifestyle**

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

**Weight**

- Underweight
- Normal for height
- Overweight
- Very overweight

**Genitourinary**

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

**Musculoskeletal**

- Pain, weakness, numbness in:
- Arms
  - Feet
  - Hands
  - Joints
  - Legs
  - Hips
  - Neck
  - Shoulders
  - Pain all over
  - Cold limbs
  - Knee problems
  - Low back pain
  - All over weakness
  - Lack of strength
  - Broken bones

**Skin**

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

**Neurologic**

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures

- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

**Emotional**

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

**Men Only**

- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Low sexual energy

**Women Only**

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy periods
- <25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Low sexual energy
- Vaginal discharges
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant



# Women's Fertility History

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Age at which menses began \_\_\_\_\_

Have you ever had pelvic inflammatory disease?  Yes  No  
Were you treated for it?  Yes  No

How \_\_\_\_\_

Are your periods painful?  Yes  No

How many days does the pain last? \_\_\_\_\_

How many days do you normally bleed? \_\_\_\_\_

How heavy is the bleeding?  Light  Normal  Heavy

What color is the blood?  Light red  Red  Dark red  Purple  
 Brown  Black

Is there clotting?  Yes  No

Do you have premenstrual tension?  Yes  No

Does your face break out before or during your period?  Yes  No

Do your breasts become tender premenstrually?  Yes  No

Do you bleed or spot between periods?  Yes  No

Are your menstrual cycles spaced irregularly?  Yes  No

How many days are there from from one period to the next? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Number      Years

How many pregnancies have you had?      \_\_\_\_\_

How many children do you have?      \_\_\_\_\_

How many abortions have you had?      \_\_\_\_\_

How many miscarriages have you had?      \_\_\_\_\_

How many times has a D&C been performed?      \_\_\_\_\_

Have you ever had an abnormal pap smear?  Yes  No

Have you ever had a cervical biopsy, operation, cauterization or conization?  Yes  No

Have you ever had a venereal disease?  Yes  No

Do you get yeast infections regularly?  Yes  No

Have you ever been diagnosed with a chlamydial infection?  Yes  No

Do you have chronic vaginal discharge?  Yes  No

Do you have any sores on your genitalia?  Yes  No

Date of last Pap smear \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids or polyps?  Yes  No

Have you ever been diagnosed with endometriosis?  Yes  No

Have you been diagnosed with pelvic adhesions?  Yes  No

Have you been diagnosed with any pelvic abnormalities?  Yes  No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began?  Yes  No

How? \_\_\_\_\_

Do you ovulate on your own?  Yes  No

On what day of your cycle? \_\_\_\_\_

Do your breasts get tender at/during ovulation?  Yes  No

Do you get premenstrual low back pain? Yes No

Do your bowel movements become loose at the beginning of you period?  
 Yes  No



# Women's Fertility History *Continued*

Have you had fertility treatments?  Yes  No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

Have you taken medication to help you ovulate?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

Have your fallopian tubes been evaluated medically?  Yes  No

What were the results? \_\_\_\_\_

Have you had any tubal operations?  Yes  No

Have you had any hormone laboratory tests performed?  Yes  No

What were the results? \_\_\_\_\_

Do you have a single partner with whom you have been trying to conceive?  Yes  No

How long have you been married or living together? \_\_\_\_\_

Has he had a fertility workup?  Yes  No

What were the results? \_\_\_\_\_

Is your partner supportive of your wish to conceive?  Yes  No

Have you taken oral contraceptives?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had an IUD?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever taken DepoProvera?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

Have you had a diagnosis relating to infertility?  Yes  No

What was it? \_\_\_\_\_

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  Yes  No

With what? \_\_\_\_\_

Do you use vaginal lubricants?  Yes  No

Are you more than 20% over your ideal body weight?  Yes  No

Are you more than 20% below your ideal body weight?  Yes  No

Do you have a stressful occupation?  Yes  No

Do you exercise regularly?  Yes  No

Do you have excessive facial hair?  Yes  No

Do you have excessively oily skin?  Yes  No

Have you experienced excessive loss of head hair?  Yes  No

Have you noticed discharge from your nipples?  Yes  No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?  Yes  No

Have you been exposed to any known environmental toxins or hormones?  Yes  No

Are you presently taking steroids?  Yes  No

COMMENTS/NOTES