

CURRENT AND FORMER CONDITIONS

Name: _____ Date: _____

Please circle current conditions, and put a check mark in the box for former conditions.
State duration, frequency, intensity and pain in the space beside current symptoms.

GENERAL SYMPTOMS

- Allergies
- Tremors
- Headache
- Fever
- Profuse sweating
- Night sweats
- Fainting
- Dizziness/vertigo
- Convulsions
- Seizures/Epilepsy
- Disturbed sleep
- Fatigue
- Nervousness
- Depression
- Loss of weight
- Forgetfulness
- Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, or feet
- Confusion
- Auto Immune Deficiency
- Paralysis
- Anxiety
- Mood swings
- Eating disorder
- Alcohol addiction
- Drug addiction
- Cold hands/feet
- Cancer
- Anemia
- Loss of balance
- Numbness/Tingling
- Slow wound healing
- Chronic infections
- Chronic Fatigue Syndrome
- Hepatitis
- HIV/AIDS

EYES, EARS, NOSE & THROAT

- Failing vision
- Near sighted
- Glasses/contacts
- Eye floaters/spots in front of eyes
- Eye tearing
- Eye dryness
- Eye redness
- Eye itching
- Eye pain
- Eye strain
- Cross eyed

- Night blindness
- Cataracts
- Blurry vision
- Color blindness
- Eye inflammation
- Glaucoma
- Deafness
- Earache
- Loss of hearing
- Ear discharge
- Ear noises
- Ear ringing
- Nose bleeds
- Nasal obstruction
- Nasal drainage
- Loss of smell
- Sinus problems
- Frequent sore throats
- Dry throat
- Sores on Lips or tongue
- Dry mouth
- Hoarseness
- Difficult speech
- Difficult swallowing
- Loss of taste
- Change in tastes
- Teeth grinding
- Bleeding gums
- Sensitive teeth
- TMJ/jaw problems
- Mucus
- Copious saliva

SKIN & HAIR

- Skin eruptions
- Clammy skin
- Dryness
- Bruises easily
- Rashes
- Boils
- Itching
- Eczema
- Ulcerations
- Acne
- Hives or allergy
- Sensitive skin
- Purpura
- Hair loss
- Dandruff
- Changes in skin or hair

RESPIRATORY

- Frequent common colds
- Chronic cough
- Cough/spit up phlegm
- Cough/spit up blood
- Chest pain
- Difficult breathing
- Wheezing
- Pneumonia
- Bronchitis
- Shortness of breath
- Asthma
- Emphysema
- Tuberculosis
- Difficulty breathing when lying down

CARDIOVASCULAR

- Pace maker
- Rapid beating heart
- Palpitations/fluttering
- High blood pressure
- Low blood pressure
- Pain over heart
- Hardening of arteries
- Swelling of feet or hands
- Poor circulation
- Varicose veins
- Heart disease
- Chest pain
- Stroke

GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Difficult chewing
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Abdominal pain/cramps
- Distention of abdomen
- Ulcers
- Heartburn
- Bloating
- Epigastric pain
- Bad breath
- Constipation
- Diarrhea
- Black stools
- Blood in stools

Over →

- Mucus in stools
- Hemorrhoids (piles)
- Rectal pain
- Chronic laxative use
- Intestinal worms
- Liver trouble/disease
- Gall bladder trouble/disease
- Jaundice
- Weight trouble

ENDOCRINE

- Hypothyroid
- Hyperthyroid
- Hypoglycemia
- Diabetes
- Night sweats
- Feeling hot or cold

GENITO-URINARY TRACT

- Frequent urination
- Scanty urine
- Heavy urine flow
- Difficult urination
- Urgency to urinate
- Inability to control/hold urine
- Painful urination
- Blood in urine
- Pus in urine
- Foul smelling urine
- Urine color _____
- Frequent urination at night # _____
- Bed wetting
- Frequent UTI
- Kidney stones
- Kidney disease
- Venereal disease _____
- Sores on genitals

MALE

REPRODUCTIVE

- Prostate problems
- Testicular pain/swelling
- Penile discharge
- Impotence
- Reduced sexual energy

FEMALE

REPRODUCTIVE

- Hot flashes
- Menopausal symptoms
- Difficulty conceiving
- Nipple discharge
- Vaginal discharge
- Vaginal odor
- Vaginal pain
- Breast lumps/swelling
- Breast pain/tenderness
- Reduced sexual energy
- Bleeding between cycles
- Premenstrual problems/PMS
- Painful menstrual periods
- Irregular cycles
- Cramps or backaches
- Light flow
- Heavy flow
- Clotting
- Age of 1st menses _____
- # of days of menses _____
- Length of cycle _____
- Birth control type _____
- # of pregnancies _____
- # of miscarriages _____
- # of abortions _____
- # of live births _____
- Pregnancy complications: _____
- _____
- Age at menopause _____
- Other menstrual problems: _____
- _____
- _____

MUSCLE & JOINT

- Stiff/painful neck
- Shoulder pain/tension
- Pain between shoulders
- Upper back pain
- Mid back pain
- Low back pain
- Painful tail bone
- Spinal curvature
- Muscle spasms/cramps
- Muscle pain
- Muscle weakness
- Walking problems
- Sciatica
- Hernia
- Hand/wrist pain
- Foot/ankle pain
- Knee pain
- Hip pain
- Leg pain
- Swollen joints _____
- Painful joints _____
- Arthritis _____
- Bone problems _____

OTHER CONDITIONS:

- _____
- _____
- _____
- _____

I understand that **Good Health Acupuncture & Chinese Herbs, Inc.** will question me about my health status, and I agree to provide information relating to all medications, treatments, physical impediments, and medical conditions, before participating. I certify that the information I provide to **Good Health Acupuncture & Chinese Herbs, Inc.** about my health history and current health status is, to the best of my knowledge, complete and accurate, and ***I agree and understand it is my responsibility to inform Good Health Acupuncture & Chinese Herbs, Inc. in the event of any change in my health or medical status.***

Patient's Signature: _____

Date: _____