Barton Acupuncture 520-869-9868

# CONFIDENTIAL MEDICAL HISTORY

This information is essential in helping to make an accurate diagnosis and provide you with the most effective treatment possible. Please fill out this form completely and as accurately as you can. Attach a separate page or use the back of this form if needed.

Name:_____ Date_____

Birth date:_____ Height____Weight____ Blood pressure_____ Date of last physical_____

Describe your main complaint:_____

_____

What has been diagnosed? (by a physician):_____

_____

Are you currently being treated by a physician? Yes___ No___ If yes, for what?_____

_____

Any problems/ complications with your birth? Please circle: Premature overdue c-section prolonged labor jaundice other (please specify):_____

**Vaccination History**: Any negative reactions that you remember?_____

_____ Any unusual vaccinations?_____

**Surgeries & Injuries**: List any surgeries (even minor surgeries) or injuries. Please only list major injuries **or** ones that have had a lasting impact. (use the back of this form if necessary):

**Childhood**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

**Adolescence**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

**Adulthood**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Do you have any scars (even minor ones) from any of the above? Please list: _____

_____

_____



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Name:_____ Date_____

**Please place a check by any of the following that are part of your medical history**:

___pregnancy (#____ ) ___pace maker ___HIV+ ___hepatitis (type____ )
___herpes (type____ ) ___bruise easily ___seizures ___cancer (type_____ )

**Family History**

Has any member of your immediate family had any of these conditions? (place letter by all that apply)

a. asthma
b. cancer
c. diabetes
d. seizures
e. heart disease
f. high blood pressure
g. stroke
h. alcoholism
i. high cholesterol
j. neurological disorders
k. psychological disorders
l. orthopedic disorders
m. food allergies (dairy, wheat, etc)
n. thyroid disease
o. other (please specify): _____

mother_____
father_____
brother_____
sister_____
maternal grandmother_____
maternal grandfather_____
paternal grandmother_____
paternal grandfather_____
aunt _____
uncle _____

**Medications/ Supplements/ Herbs/ Vitamins/ Minerals**

Please list any medications, supplements, herbs, vitamins or minerals you are currently taking:

_____
_____
_____
_____
_____

Is there anything else that is significant in your health history?_____
_____
_____

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Name:_____ Date:_____

SYMPTOM/ CONDITION LIST

**Circle** any problem, symptom or disease that *bothers you now*. **Underline** anything that *bothered you in the past*, (***regardless of how long ago it was***). Please be as accurate as possible.

**Skin**: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

**Heart and vascular**: fast pulse (over 100 beats/ min.) slow pulse (under 60 beats/ min.) palpitation irregular pulse feeling of pressure in your chest shortness of breath chest pain pericarditis dizziness migraine headache with nausea cold hands/ cold feet Raynaud's disease flushed face anemia high or low blood pressure cold sweats red face varicose veins stroke deep vein thrombosis feel dizzy or faint when standing up quickly or standing for a long time

**Gastrointestinal**: constipation diarrhea no appetite stomach pain indigestion heartburn gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spasm peritonitis pancreatitis appendicitis irritable bowel polyps GI tumors food allergy/ sensitivity

**Respiratory**: asthma bronchitis emphysema chronic cough wheezing pneumonia lung abscess environmental allergies (pollen, dander, grass, etc)

**Hormone Imbalance**: low thyroid over active thyroid diabetes hypoglycemia

other hormone imbalances:_____

**Male**: impotency premature ejaculation prostate gland problem vasectomy infertility low libido incomplete urination/ dribbling undescended testicle(s)

**Female**: heavy/ light/ irregular periods cramping PMS emotional reactions cysts fibroids endometriosis miscarriage menopause symptoms tubal ligation infertility low libido frequent bladder infections

**Neurological**: tremors ticks twitching Bell's Palsy paralysis numbness tingling burning pain

**Autoimmune & inflammatory conditions**: Hashimoto's disease (thyroid) rheumatism colitis systemic lupus erythematosus Crohn's disease alopecia (baldness) cellulitis atopic dermatitis neurodermatitis vulvitis low immunity

**Effects of focal infections**: rheumatic disease rheumatic fever skin disease streptococci infections staphylococci infections

**Connective tissue**: arthritis myofascial pain syndrome fibromyalgia tendonitis plantar fasciitis

**Ear nose & throat**: deafness tinnitus (ringing in the ear) itchy ear ear pain ear infections sore throat sinus headaches yellow mucus stuff nose post nasal drip dry throat itchy throat swollen glands constant sinus congestion streptococci throat infections easily catch colds

**Oral disease**: bleeding gums periodontitis dental abscess mumps toothaches without cavities TMJ stomatitis (inflammation of the mouth) loose teeth

**Other**: insomnia exhaustion psychosomatic disorder constant slight fever kidney stones emotional problems (angry, irritable, depressed, anxious, etc.) difficult concentrating on a task car/ sea/ air sickness no appetite for breakfast moody in morning easily jet lagged never sweat unusual sweating (palms, soles, elsewhere) trouble adjusting to temperature change gall stones

**Before noon time**: no energy feel spacey scattered mind long shower or bath makes you feel dizzy energetic all evening, but hate to wake up early in the morning

**Medication and Drugs**: Birth control tobacco caffeine alcohol marijuana stimulants

**Not listed above**: _____

_____

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