寿
longevity
jeanette w. moy
M.S., L. Ac.

Patient Health History

Thank you for answering the following questions. A complete understanding of your health status will facilitate proper evaluation

Date:_____

Last name: _____ First name:_____ MI: ____ SS#:_____

Date of Birth:_____ Age:_____ Gender:_____ Height:_____ Weight:_____

Address:_____City_____State_____Zip_____

Home Phone:_____ Work Phone:_____ Email:_____

Occupation:_____ Employer_____

Duties at your Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner ☐ Civil Union

Emergency Contact: _____ Phone #:_____

Relationship:_____

IF UNDER THE AGE OF 18, PARENTS NAMES/GUARDIAN REQUESTED:
Mother's Name:_____ Father's Name:_____

Guardian's Name:_____ Contact #:_____

INSURANCE INFORMATION

ID # _____ Group #:_____

Name of Company:_____ Phone # of Company:_____

Name on Policy:_____ Relationship:_____

REFERRAL INFORMATION

How did you first hear about *Jeanette W. Moy, MS, L. Ac*? Circle all that apply:

Website drive-by/walk-by yellow pages newspaper ad poster/flyer

Radio brochure classes listing other_____

Referred by:_____

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PATIENT HEALTH HISTORY

Primary Care Physician:_____ Phone #:_____

Date of last Medical Exam:_____ Allergies (medication, food, bee etc.):_____

List all Physicians (and their specialties) that you have seen and the corresponding condition for which you were treated.

_____

_____

_____

List the dates and circumstances of all hospitalizations including accidents, illnesses, operations etc

Reason for hospitalization	Month/yr.	Hospital and location

List most recent X-ray exposure_____

Medications and Supplements: list all drugs (prescription and non-prescription), vitamins, minerals, herbs or other food supplements that you are presently taking on a regular basis, as well as drugs you have taken in the last year and the duration you took them.

Name of drug/supplement	Dosage strength (#/day)	Reason for taking

FAMILY HEALTH HISTORY

Has any member of your family had (please check and indicate relationship):

[] Arthritis_____
[] Heart disease_____
[] High blood pressure_____
[] Cancer_____
[] Epilepsy_____
[] Diabetes_____
[] Allergies_____
[] Kidney Disease_____
[] Mental Disorder_____
[] Other Serious Disease_____

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SYMPTOMS SURVEY

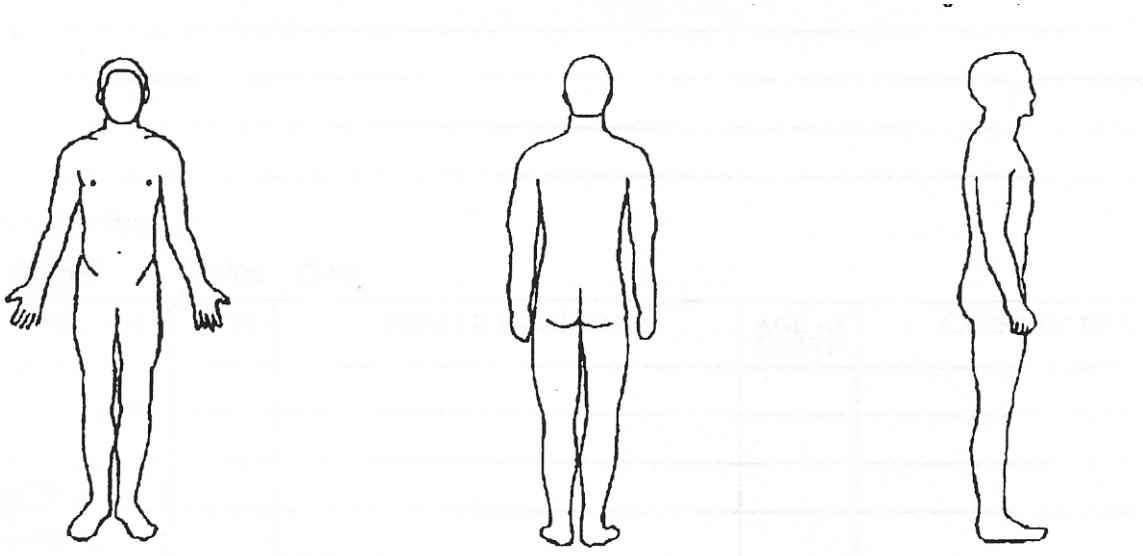
Please describe your problem and tell how it began_____
_____
_____
_____

When did you first notice this problem?_____ Have you experienced this problem before?_____
Is the problem of a mild, medium or severe nature?_____ Does it keep you from your daily activities?_____

Circle the words that best describe your symptoms: dull, aching, sharp tingling, burning itching, numb, other_____

Is this a constant problem or does it come and go?_____ Is it worse at a specific time of day?_____
Has the problem become worse, stayed the same or improved since the onset?_____
Does it extend or radiate into other areas?_____ Does anything make the symptoms better?_____
Have you seen another health care professional for this problem?_____
If so, what was the diagnosis and treatment?_____

Please shade in the areas of difficulty, pain or injury.



Have you ever had any of the following conditions (please check):

[] Anemia
[] Arthritis
[] Stroke
[] Pneumonia
[] Epilepsy
[] Hepatitis
[] Diptheria
[] Hypertension
[] Emphysema
[] Chicken Pox
[] Malaria
[] Diabetes
[] Tuberculosis
[] Eczema
[] Measles
[] Mumps
[] Bronchitis
[] Appendicitis
[] Cancer
[] Influenza
[] Osteoporosis
[] Hypoglycemia
[] Meningitis
[] Lumbago
[] Mental Disorder
[] Polio
[] Ulcer
[] Asthma
[] Colitis
[] Gout
[] Thyroid Disease
[] Shingles
[] Migraine Headache
[] Heart Disease
[] Rheumatic Fever
[] AIDS
[] Alcoholism
[] other Chemical Dependency
[] Venereal Disease
[] Pleurisy
[] Small Pox
[] Encephalitis
[] Whooping Cough
[] Scarlet Fever
[] Gallbladder Disease
[] Diverticulitis

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SYMPTOMS SURVEY

CARDIOLOGY:

Past	now	
[]	[]	Rapid Beating Heart
[]	[]	Slow Beating Heart
[]	[]	High Blood Pressure
[]	[]	Low Blood Pressure
[]	[]	Pain over your Heart
[]	[]	Ankles Swell
[]	[]	Varicose Veins
[]	[]	Shortness of Breath
[]	[]	Cold Hands and Feet
[]	[]	Blood Clots
[]	[]	Skipped Heartbeat
[]	[]	Heart Murmur
[]	[]	Chest Pain w/ left arm pain

RESPIRATORY:

Past	now	
[]	[]	Chronic cough
[]	[]	Spitting Phlegm
[]	[]	Spitting Blood
[]	[]	Difficult Breathing
[]	[]	Wheezing
[]	[]	Allergies
[]	[]	Night Sweats
[]	[]	Snoring
[]	[]	Sinus Pain/Congestion
[]	[]	Nasal Polyps
[]	[]	Tightness in Chest

URINARY:

Past	now	
[]	[]	Frequent Urination
[]	[]	Painful Urination
[]	[]	Blood in Urine
[]	[]	Frequent Kidney Infections
[]	[]	Bed Wetting
[]	[]	Inability to Control Urine
[]	[]	Urgent Urination
[]	[]	Urine Dribbles
[]	[]	Difficulty Urinating
[]	[]	Kidney Stones
[]	[]	Bladder Infections
[]	[]	Excessive Thirst

GASTROINTESTINAL:

Past	now	
[]	[]	Belching or Gas
[]	[]	Heartburn
[]	[]	Stomach Pain
[]	[]	Poor Digestion
[]	[]	Nausea
[]	[]	Vomiting
[]	[]	Poor Appetite
[]	[]	Excessive Hunger
[]	[]	Difficult Swallowing
[]	[]	Change in Bowel Habits
[]	[]	Pain After Eating
[]	[]	Constipation
[]	[]	Laxative/Enema Use
[]	[]	Black Stools
[]	[]	Light-colored Stools
[]	[]	Hard Stools
[]	[]	Diarrhea
[]	[]	Feeling of Incomplete Bowel Evacuation
[]	[]	Burning or Itching Anus
[]	[]	Hemorrhoids
[]	[]	Feel Shaky When Hungry
[]	[]	Afternoon Headache
[]	[]	Crave Sweets or Coffee
[]	[]	Greasy Foods Upset
[]	[]	Abdominal Pain or Cramps
[]	[]	Abdominal Bloating

NERVOUS:

Past	now	
[]	[]	Depression
[]	[]	Anxiety
[]	[]	Excessive Fear
[]	[]	Difficulty Sleeping
[]	[]	Nervousness
[]	[]	Hear Sounds or Voices
[]	[]	See Visions
[]	[]	Dizziness
[]	[]	Fainting
[]	[]	Confusion
[]	[]	Lack Energy
[]	[]	Outbursts of Anger
[]	[]	Nightmares
[]	[]	Forgetfulness
[]	[]	Awaken Tired, Exhausted
[]	[]	Convulsions
[]	[]	Stuttering
[]	[]	Other _____

Head/Ear/Eyes/Nose/Throat (HEENT):

Past	now	
[]	[]	Headaches
		[]front
		[]left side
		[]right side
		[]back
[]	[]	Sinus Trouble
[]	[]	Jaw Pain
[]	[]	Allergies
[]	[]	Grind Teeth
[]	[]	Clench Teeth
[]	[]	Visual Problems
[]	[]	Light Sensitivity
[]	[]	Hearing Problems
[]	[]	Excessive Ear Wax
[]	[]	Excessive Dry Skin
[]	[]	Dandruff
[]	[]	Acne
[]	[]	Eczema
[]	[]	Psoriasis
[]	[]	Changing Moles
[]	[]	Canker Sores
[]	[]	Bleeding Gums
[]	[]	Sore Throats/Colds
[]	[]	Difficulty Swallowing
[]	[]	Sore Tongue
[]	[]	Swollen Glands
[]	[]	Frequent Bloody Noses
[]	[]	Change in Sense of Smell
[]	[]	Ringing in Ears
[]	[]	Itching in Ears

MUSCLES/JOINTS/NERVES:

Past	now	
[]	[]	Weakness
[]	[]	Twitching
[]	[]	Neck Pain
[]	[]	Pain Btw. Shoulder Blades
[]	[]	Low Back Pain
[]	[]	Spinal Curvature
[]	[]	Difficulty Walking
[]	[]	Swollen Joints
[]	[]	Muscle Spasms
[]	[]	Cracking Noises in Neck
[]	[]	Stiffness Upon Waking
[]	[]	Shoulder/Arm/Hand Pain
[]	[]	Leg/Knee/Ankle/Foot Pain
[]	[]	Numbness, Tingling, Burning, "Sleeping" or Prickly Sensation: Arms: []R []L Hands: []R []L Legs: []R []L Feet: []R []L
[]	[]	Arch Pain
[]	[]	Heel Pain
[]	[]	Foot Problems

WOMEN ONLY:

Past	now	
[]	[]	Painful Menstrual Periods
[]	[]	Irregular Cycles
[]	[]	Excessive Flow
[]	[]	Cramps
[]	[]	Backache During Period
[]	[]	Moodiness Related to Cycle

Days Between Periods_____
Days Period Lasts_____
Children Birthed_____
Pregnancies Terminated_____

[]	[]	Bloating
[]	[]	Food Cravings
[]	[]	Breast Swelling/Tenderness
[]	[]	Breast Lumps
[]	[]	Vaginal Discharge
[]	[]	Hot Flashes
[]	[]	STDs
[]	[]	Hormone Replacement Therapy
[]	[]	Menopause
[]	[]	Sexual Dysfunction
[]	[]	Taken Oral Contraceptives

MEN ONLY:

Past	now	
[]	[]	Prostate Trouble
[]	[]	Lumps in Testicles
[]	[]	Swelling of Testicles
[]	[]	Discharge from Penis
[]	[]	Sores on Genitals
[]	[]	STDs
[]	[]	Sexual Dysfunction

LIFESTYLE/DIET

Do you smoke? If so, for how many years, and how many times per day?_____

Do you drink alcoholic beverages? If so, what type and how many times per week?_____
_____

Do you drink caffienated beverages? If so, what type and how often per day?_____
_____

Optional: do you use drugs socially? If so, list them and their frequency._____
_____

List all exercise and physical activities you engage in, and how often you do them (hobbies, sports etc.)_____
_____
_____

List all foods which disagree with you:_____
_____
_____

List your favorite, craved or particularly enjoyed foods and beverages:_____
_____
_____

Intake per day: indicate how often per week you consume the following food items:

Coffee_____
Decaf coffee_____
White sugar_____
Artificial sweeteners_____
Tea_____
Herbal tea_____
Salt_____
Pepper_____
Soda_____
Diet soda_____
Chocolate_____
Candy_____
Fruit juice_____
Cake_____

Cookies_____
Milk_____
Ice cream_____
Butter_____
Cheese_____
Fried foods_____
White bread_____
Whole grain bread_____
White rice_____
Pasta_____
Beef_____
Veal_____
Pork_____
Deli meats_____

Canned foods_____
Chicken_____
Turkey_____
Shellfish_____
Vegetables_____
Raw fish_____
Eggs_____
Fish_____
Tuna_____
Cooked tomato products_____