|  |  |
| --- | --- |
| **Name:** | **DOB:** |
| **Email:** |  |

|  |  |  |
| --- | --- | --- |
| **Reason for visit today:** | **Referred by:** | **Gender Pronoun (Please Circle):**  **He/Him She/Her They/Them Other** |

|  |
| --- |
| **(Non-SIU Patients Only) Are you currently using pharmaceutical medications, supplements, herbal medications?  Yes  No If yes, please list (If you need more room, continue on the back of sheet):** |
| **Allergies:** |
| **Primary care physician:** |
| **Other provider(s):** |

**Family Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
|  Allergies |  High Blood Pressure |  Cancer |  Diabetes |
|  Asthma |  Heart Disease |  Stroke |  Seizures |
|  Other (list) |  |  |  |

**Your Present and Past Medical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  AIDS/HIV |  Heart conditions | |  Scarlet Fever |  Urinary Tract Infections | |
|  Alcoholism |  Hepatitis | |  Sexually Transmitted Infection(s) |  | |
|  Appendicitis |  Herpes | |  Smoking (now or in the past) |  | |
|  Asthma or Breathing Problems |  High Blood Pressure | |  Stroke |  | |
|  Atherosclerosis |  IBS/IBD  Measles | |  Stress |  | |
|  Cancer or tumors |  Measles | |  Thyroid Disorders | Other History | |
|  Chicken Pox |  Multiple Sclerosis | |  Tuberculosis |  | |
|  Diabetes |  Pacemaker or Irregular Heartbeat | |  Weight Loss/Gain |  | |
|  Gout |  Rheumatic Fever | |  Ulcers |  | |
|  Surgeries (List) (Not performed in Springfield) | |  | | |  |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |

**Lifestyle Habits**

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol | Smoking | Marijuana | Illicit substances |
|  |  |  |  |
| /week | packs/day | /week | \_\_\_\_\_\_\_\_/week |

**Exercise?**

|  |
| --- |
| Please Describe |

**Please describe your typical diet for each meal. Note between-meal or late night snacks as well.**

|  |
| --- |
| Breakfast |

|  |
| --- |
| Lunch |

|  |
| --- |
| Dinner |

**Gynecological**

|  |  |  |  |
| --- | --- | --- | --- |
| Length of Period:  \_\_\_\_\_\_\_\_\_\_Days |  Heavy Flow |  Clots |  Breast Tenderness |
|
| Length of Cycle:  \_\_\_\_\_\_\_\_\_Days |  Light Flow |  Irregular cycle |  Breast Lumps |
|
| Age when menstruation began |  Bleeding Between Periods | Uterine Fibroids |  Vaginal Odor |
|  |
| Date of last menstrual period |  Back Pain Related to Cycle |  Menstrual Cramps | Typical Color of Menstrual Blood?   Pale Bright Red  Dark Red Purple |
|  |
| Date and result of last Pap smear |  PMS | Uterine Fibroids |  |
| At what age did you undergo menopause? | If undergoing menopause now, what are your symptoms? | | |
|  |
| Number of Pregnancies | Number of Live Births | Number of Premature Births | Number of Induced Abortions |
|  |  |  | Number of Miscarriages |

**Gan**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  Headaches |  Dry Eyes |  Anger | |  Numbness | |  Seizures |
|  Tinnitus |  Blurry Vision |  Frustration | |  Tremors | |  Stroke |
|  Dizziness |  Spots in the Eyes |  Excessive Sighing | |  Tics | |  Rib/Flank Pain |
|  Cataracts |  Red Eyes | |  Feeling of Lump in the Throat | |  Withered or Brittle Nails |  Glaucoma |
|  Excessive Tearing |  Short Temper/ Irritable | |  Feeling of Tightness in the Chest | |  Depression/Hopelessness |  |

**Dan**

|  |  |  |  |
| --- | --- | --- | --- |
|  Bitter Taste |  Indecisiveness |  Stiff Neck |  Ear Infection |
|  Timidity |  Yellow Complexion |  Fatty Stools |  Lack of Initiative |
|  Gallbladder Issues |  |  |  |

**Xin**

|  |  |  |  |
| --- | --- | --- | --- |
|  Very Talkative |  Frequent Bursts of Nervous Laughter |  Red Face |  Chest Pain |
|  Anxiety |  Excessive Dreaming |  Bitter Taste in the Morning |  Heart Disease |
|  Insomnia |  Dream Disturbed Sleep |  Aphasia or Speech Difficulties |  Shortness of Breath |
|  Phobias |  Stuttering |  Mouth and Tongue Sores |  Tachycardia |
|  Easily Startled |  Palpitations |  Fainting |  Irregular Heartbeat |

**Pi**

|  |  |  |  |
| --- | --- | --- | --- |
| Lack of Taste | Abdominal Pain | Foggy Thinking | Bleed or Bruise Easily |
| Loss of Appetite | Bloating | Heavy Limbs | Vaginal Discharge  Yellow  White |
| Excessive Saliva | Diarrhea | Fatigue | Edema |
| Flatulence | Hemorrhoids | Worry | Muscle Weakness |
| Loose Stools | Prolapse |  |  |

**Wei**

|  |  |  |  |
| --- | --- | --- | --- |
|  Excessive Appetite |  Vomiting |  Loss of Appetite |  Belching |
|  Epigastric Pain |  Vomiting of Clear Fluid |  Nausea |  Swelling and Pain of the Gums |
|  Acid Reflux (GERD) |  Vomiting Bile (green) |  Tiredness in the Morning |  Bleeding Gums |
|  |
|  Bad Breath |  Vomiting Blood |  Hiccup |  |

**Fei**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Acute Cough | |  Pneumonia |  Spontaneous Sweating |  Loss of smell |
|  Chronic Cough | |  Emphysema |  Yellow Phlegm |  Bleeding from the Nose |
|  Asthma | |  Wheezing |  White Phlegm |  Sinus Problems |
|  Shortness of  Breath | |  Grief or Sadness |  Fullness in the Chest |  Sore Throat |
|  Difficulty Breathing when Lying Down |  Skin Problems | |  Weak Voice |  Frequent Colds |
|  | |  |  |  |

**Da Cheng**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Constipation |  Blood in the Stool | |  Itchy Anus |  Fever |
|  Diarrhea |  Foul Smelling Stools | |  Abdominal Pain and Distention |  Cold Sensation in the Abdomen |
|  Black Stools |  Fatigue after Passing Stool | |  Burning Anus |  Rectal Pain |
|  Tenesmus (Strong Urge to Pass Stool) |  | |  |  |
| Number of bowel movements per day \_\_ | |  | | |

**Shen**

|  |  |  |  |
| --- | --- | --- | --- |
|  Bedwetting |  Increased Libido |  Hot Flashes |  Arthritis |
|  Frequent Urination |  Decreased Libido |  Night Sweats |  Brittle Bones |
|  Incontinence |  Impotence |  Low Grade Fever in Afternoon and/or Evening |  Problems with Hearing |
|  Edema |  Premature Ejaculation |  Problems with Concentration |  Black Circles Under Eyes |
|  Weakness of the Knees and Ankles |  Nocturnal Emission |  Chronic Sore Throat |  Teeth Problems |
|  Low Back Pain |  Infertility |  Memory Problems |  Erectile Dysfunction |

**Pan Guang**

|  |  |  |  |
| --- | --- | --- | --- |
|  Pain with Urination |  Urgent Urination |  Unable to hold urine |  Wake up to Urinate Often |
|  Frequent Urination |  Blood in Urine |  Incomplete Urination |  Bladder and/or Kidney stones |