ISLAND Acupuncture and Herbs
Confidential Patient Health Profile

The following information is used to help determine how to best treat your health issues. Please complete to the best of your abilities.

Personal Information:

Name: ________________________________

Address: ________________________________

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Occupation: ________________________________

Phone: h: __________ w: ______________

Sex: Male: ___ Female: ___

Date of Birth: _____________ Age: ___________

Physician Information:

Name: ___________________

Phone: ___________________

Emergency Contact:

Name: ___________________

Phone: ___________________

Referral Information:

Who referred you?_________________

Health Concerns: Please list the concerns you have about your health today.

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Conditions: Please check conditions you currently have or have had in the past:

- ❏ AIDS
- ❏ Alcoholism
- ❏ Allergies
- ❏ Anemia
- ❏ Anorexia
- ❏ Arthritis
- ❏ Asthma
- ❏ Bleeding Disorder
- ❏ Bronchitis
- ❏ Bulimia
- ❏ Cancer
- ❏ Cataracts
- ❏ Chemical Dependency
- ❏ Chicken Pox
- ❏ Chronic Pain
- ❏ Diabetes
- ❏ Eczema
- ❏ Emphysema
- ❏ Epilepsy
- ❏ Fatigue Problem
- ❏ Gallbladder Problem
- ❏ German Measles
- ❏ Glaucoma
- ❏ Goiter
- ❏ Gout
- ❏ Heart Disease
- ❏ Hepatitis
- ❏ Hernia
- ❏ Herpes
- ❏ High Blood Pressure
- ❏ High Cholesterol
- ❏ Intestinal Disorder
- ❏ Kidney Disease
- ❏ Liver Disease
- ❏ Lupus
- ❏ Measles
- ❏ Menstrual Disorder
- ❏ Migraines
- ❏ Miscarriage
- ❏ Mononucleosis
- ❏ Multiple Sclerosis
- ❏ Mumps
- ❏ Pacemaker
- ❏ Pneumonia
- ❏ Polio
- ❏ Prostate Problem
- ❏ Psychiatric Care
- ❏ Rheumatic Fever
- ❏ Stroke
- ❏ Stomach Disorder
- ❏ Thyroid Disorder
- ❏ Tuberculosis
- ❏ Ulcers
- ❏ Urinary Tract Infection
- ❏ Vaginal Infection
- ❏ Venereal Disease
- ❏ Other ___________
- ❏ Other ___________
- ❏ Other ___________

Family History: Check if your blood relations have had any of the following:

- ❏ Arthritis/Gout
- ❏ Asthma
- ❏ Cancer
- ❏ Chemical Dependency
- ❏ Diabetes
- ❏ Heart Disease
- ❏ High Blood Pressure
- ❏ Kidney Disease
- ❏ Stroke
- ❏ Tuberculosis
- ❏ Other ___________
- ❏ Other ___________

Symptoms: Please indicate symptoms you currently have (C) or have had in the past (P). Please note quality of symptoms.

General
❏ Fatigue
❏ Insomnia
❏ Disturbed sleep
❏ Frequent dreams
❏ Excessive sleep
❏ Dislike cold
❏ Dislike heat
❏ Weight loss
❏ Weight gain
❏ Fever
❏ Chills
❏ Alternating chills and fever
❏ Night sweats
❏ Unusual daytime sweating
❏ Usually thirsty
❏ Seldom thirsty
❏ Edema or swelling
❏ Other: ____________

Skin
❏ Rashes
❏ Hives
❏ Dry skin
❏ Acne
❏ Easily bruised
❏ Changes in lumps or moles
❏ Unusual bleeding
❏ Other

Head and Neck:
❏ Headaches (note type and location of pain)
❏ Dizziness
❏ Jaw pain
❏ Other ____________

Eyes and Ears:
❏ Failing vision
❏ Blurred vision
❏ Visual spots
❏ Night blindness
❏ Eye pain/swelling
❏ Ringing in the ears
❏ Decreased hearing
❏ Ear pain
❏ Ear discharge
❏ Other ____________

Nose, Throat, Mouth:
❏ Nose bleeds
❏ Nasal discharge/infection
❏ Frequent sneezing
❏ Change in sense of smell
❏ Sore throat
❏ Hoarseness
❏ Difficulty in swallowing
❏ Change in sense of taste

Nose/Throat/Mouth con't
❏ Tooth or gum pain
❏ Bleeding gums
❏ Mouth or tongue ulcers
❏ Other ____________

Muscles and Joints:
Pain, weakness or numbness in:
❏ Neck/Shoulder/Arm/Hand
❏ Hips/Leg/Feet
❏ Sore low back and knees
❏ Muscle cramps
❏ Body pain
❏ Heavy limbs
❏ Swollen joints
❏ Hot joints

Nervous System:
❏ Fainting
❏ Paralysis
❏ Tremors
❏ Poor balance
❏ Seizures
❏ Other ____________

Heart, Lungs and Chest:
❏ Palpitations
❏ Chest pain
❏ Tightness
❏ Rapid heart beat
❏ Irregular heart beat
❏ Swelling of the ankles
❏ Cough
❏ Dry Cough
❏ Coughing up phlegm
❏ Coughing up blood
❏ Shortness of breath
❏ Asthma/wheezing
❏ Frequent colds
❏ Pain in rib cage
❏ Other ____________

Mental/Emotional:
❏ Difficulty concentrating
❏ Poor memory
❏ Worry
❏ Anxiety
❏ Depression
❏ Irritability
❏ Frustration or anger
❏ Fearfulness
❏ Stress
❏ Other ____________

Digestive System:
❏ Nausea
❏ Vomiting food
❏ Vomiting blood
❏ Diarrhea
❏ Constipation
❏ Loose stools
❏ Bloody/black stools
❏ Stomach pain
❏ Abdominal pain
❏ Poor appetite
❏ Excessive hunger
❏ Abdominal bloating/gas
❏ Belching
❏ Indigestion
❏ Acid reflux
❏ Hemorrhoids

Urinary/Genital:
❏ Painful urination
❏ Difficult urination
❏ Frequent daytime urination
❏ Frequent nighttime urination
❏ Incontinence
❏ Cloudy urine
❏ Bloody urine
❏ Genital pain or itch
❏ Genital discharge or lesions
❏ Painful intercourse
❏ Low sexual drive
❏ Excessive sexual drive
❏ Other ____________

Male:
❏ Impotence
❏ Weak urinary stream
❏ Prostate hypertrophy
❏ Premature ejaculation
❏ Seminal emissions

Female:
❏ Irregular periods
❏ Painful periods
❏ Bleeding between periods
❏ Passing clots
❏ Scanty periods
❏ Early periods
❏ No periods
❏ PMS
❏ Menopausal symptoms
❏ Abnormal PAP smear
❏ Breast lump
❏ Breast pain or discharge
❏ Vaginal discharge
❏ Other ____________

Hospitalizations: Please note if you have ever been hospitalized and why:

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Medications and Supplements: List any medications or supplements you are currently taking.

Medication/Supplement	Dosage

Medication/Supplement	Dosage

Allergies: List any medication, food or environmental substances that you are allergic to and the reaction you have.

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Health Habits: Check which substances you use and describe how much.

Substance	✓	How much do you use/consume and how often?
Sugar		
Caffeine		
Tobacco		
Alcohol		
Recreational Drugs		
Other		

Diet: Describe your diet in general terms. Please include in your description how many meals you eat daily, how often you eat out, if you have any dietary restrictions and what your favourite foods are.

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Exercise: Do you exercise regularly?

❑ Yes
❑ No

If yes, describe the type of activity you do and how often you do it.

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Women Only: Please answer the following questions if applicable to you.

Menstrual Cycle:

Describe your typical period including any PMS symptoms you experience: ______________________

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How many days are there between your periods? __________
How many days does your period last?: ____________
Quality of Blood:
❑ Light red
❑ Bright red
❑ Dark Red
❑ Clotted
❑ Other (please describe):____
____
____

If you are in menopause please describe the age of onset and the past and current symptoms you experience(d). ____
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Pregnancy and Birthing History:
Are you currently pregnant?
❑ Yes
❑ No

Are you trying to become pregnant?
❑ Yes
❑ No

If you use birth control pleased note what method you use and how long you have been using this method: ____
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Please note the number of pregnancies you have had, the number of deliveries you have had and any related information i.e. heavy bleeding with delivery, problem free delivery etc.

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Patient Signature: ____________________________________

Date: ____________________________________