PATIENT QUESTIONAIRE

Patient Name:_____ Date: _____/_____/_____

REASON FOR VISIT

Main Complaint:_____

Present illness & Physical Examination: _____

_____

_____

Please circle degree of pain, 0 none, 10 severe pain : 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

How long have you had these problems? _____

Has a doctor previously diagnosed this condition? Yes ( ) No ( )
If so, what was the diagnosis? _____

Please tell us any medication(s) you have had or currently taking: _____

_____

MEDICAL HISTORY :Diseases, surgeries, traumas, etc:_____

ALLERGIES: _____

If a FAMILY member has had any of the following, please mark the appropriate box and explain the relationship;
□ Cancer _____ □ Heart disease _____ □ Hypertention_____

□ Lupus _____ □ Diabetes _____ □ Pace maker _____□ Other _____

Please check all of the following that apply to you:
□ Cancer/ tumor □ Diabetes □ Feeling of heaviness □ Fatigue □ Hypertention
□ Osteoporosis □ Pacemaker □ Thyroid Disease □ Stroke □ Other;_____

EMOTION
□ irritate □ startled □ always smiling □ delusion □ sad □ fear □ depressed

SLEEP
□ I sleep well at night □ I get insomnia □ Take sleeping pills or sedatives
□ Excessive dreaming □ It's hard to get up in the morning
□ Yawn frequently □ Drinking coffee irritates me :cannot sleep at night, heart throbbing

APPETITE / TASTE
□ I have a good appetite □ Normal amount □ eat a large quantity in one sitting
□ Poor appetite □ Recently weight gain □ Recently loss weight
□ difficult time enduring hunger. □ I become full after eating only a small quantity of food.

Prefer taste □ sweet □ pungent □ bitter □ sour □ salty □ meat □ vegetable
Smoking: Per day; _____ How much alcohol do you drink? _____

DRINKING HABIT

How much liquid do you drink? Water: _____ Coffee: _____ Tea: _____ Soda: _____

Circle reason for drinking: □ Thirst □ To stay healthy □ Habit □ thirsty but no desire to drink

□ Prefer cold drink □ Prefer hot drink □ No preference for temperature of the drink

□ I can take large gulps of water.

□ I sip little by little :can't even drink a full cup of water at once.

□ I lose patience when feeling thirsty □ My lips or inside of my mouth get dry often

DIGESTION

□ Digest well □ Indigestion : □ constantly □ sometimes

□ stomach upset often □ Often feel nausea □ Vomit occasionally

□ Pain with hunger □ Pain after eating □ Pain after stress □ Have gas in the bowels

□ Belch frequently □ Bloating frequently □ bowel sound □ become nauseous when I brush my teeth

URINATION

□ Feel refreshed after urinating □ Don't feel refreshed even after urinating

□ Go to the bathroom often for urination :day_____, night_____

□ Amount of urine is very small □ scanty urine □ Dribbling

□ Color of urine has a yellowish / red tint □ Cloudy urine

□ Often find that underwear gets slightly wet after urinating

□ Hard to release urine □ Feel pain while or after urinating

STOOL

□ Bowel movements _____ times per day □ Constipation

□ I do not feel much discomfort even after not having excreted for several days.

□ I feel major discomfort if I don't excrete even one day.

□ Feel refreshed after bowel movement □ feeling something remained behind

□ loose or sometimes like water like mucus □ I have diarrhea when I eat cold foods.

□ Go to stool right after meal □ diarrhea often alternating with constipation

□ I take health aid food for smooth passage or take a laxative

TEMPERATURE

□ A lot of discomfort in the heat □ A lot of discomfort in the cold

□ Alternation of hot and cold □ Get flushed easily

□ Feel feverish somewhere in my body. / □ Face □ hand □ feet / when; □ tired □ anytime)

HEAD

Get headaches: □ migraine □ back □ front when:_____

Dizziness : when _____

CHEST

□ asthma □ palpitation □ pent-up feelings □ Burning sensation □ anxiety

□ Hard to inhale □ Hard to exhale □ short breath □ hiccup □ a sigh

□ Feels stiff or I have prickly pain in my chest

□ prefer loose fitting cloth because tight fitting clothes makes it hard for me to breathe

Name:_____ Date: _____/_____/_____

EARS
□ Ringing sound □ hard of hearing □ tympanitis □ discharging □etc _____

EYES
□ red eyes □ blurred vision □ excessive tearing □ dryness □ cataract □ glaucoma

NOSE/TROAT
□ Thyroid swell easily □ abscess mouth easily
□ feeling of plum in the throat □ get cold easily
□ Respiratory problem □ cough □ sneeze □ running nose □ congestion □sinuses
□ Phlegm/ □ watery □ sticky / color; □ green □ yellow □ clear

NECK
□ stiffness □ neck disk □ hyperthyroidism □ hypothyroidism □ lymph node □other_____

SPINE PAIN
□ shoulder □ upper back □ middle back □ lower back

PERSPIRATION
□ Perspire easily □ Night sweat □ Don't perspire
□ Perspire only on some parts of my body : brow, chest, hands, feet, groin
□ Get tired after sweating □ Feel good after sweating
□ I don't go to saunas because of the stuffiness.

EXTREMITIES/JOINTS
□ numbness □ I fall ill when I'm tired
□ swell easily / □ face □ hand □ leg □ feet / when; □ morning □evening □ throughout the day
□ shake muscle □ urticaria often □ bruise easily
□ There are times when my legs suddenly feel weak.

MISCELLANEOUS
□ Low energy □ Low libido □ Infertility

FOR GENTLEMEN ONLY
□ Impotence □ premature □ Prostate problems

FOR LADIES ONLY

Menstruation began at ____ yrs old Are you pregnant now? □ Yes □No □Unknown
Number of deliveries: _____ Number of abortions/miscarriage: _____
Menopause □Yes □No If so, since when? _____yrs old.
□ Suffer menstrual cramps often □ Appetite improves before menstruation
□ Easily irritated before having my period □ Have mucus (yellowish / white) □ Itchy private part(s)
□ Regular menstrual cycle _____days □ Irregular menstrual cycle _____days
□ Excessive clots □ Hypomenorrhea □ PMS □ Amenorrhea □ Dark red □Brown red