Carlsbad Village Acupuncture

Patient History

Patient Name _____ Date _____

Date of you last general physical exam: _____

Blood Pressure
___ High
___ Low
___ Don't Know

Cholesterol
____ High
____ Low
____ Don't Know

Allergies (please list specifics)
___ Medications _____
___ Food _____
___ Other _____

Medications / Vitamins / Supplements / Herbs - please list all that you are currently taking

Name	Dosage	Reason for taking	How long you've been taking

Please indicate the use and frequency of:
___**Alcohol** how much? _____
___**Caffeine** how much? _____
___**Non-medical drugs** how much? _____

Please list any **surgeries** and/or **serious injuries** you have had and the approximate dates:

_____

_____

_____

Medical History - please mark any conditions that you have had or currently have

	When?
☐ AIDS / HIV infection	_____
☐ Alcohol / drug dependency	_____
☐ Asthma	_____
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Epilepsy	_____
☐ Gallstones	_____
☐ Heart Disease	_____
☐ Hepatitis	_____
☐ Kidney or bladder trouble	_____
☐ Seizures	_____
☐ Sexually Transmitted Diseases	_____
☐ Stroke	_____
☐ Tuberculosis	_____

Family Medical History - please indicate any conditions for parents, grandparents or siblings

	Who?
☐ AIDS / HIV infection	_____
☐ Alcohol / drug dependency	_____
☐ Asthma	_____
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Epilepsy	_____
☐ Gallstones	_____
☐ Heart Disease	_____
☐ Hepatitis	_____
☐ Kidney or bladder trouble	_____
☐ Seizures	_____
☐ Sexually Transmit Diseases	_____
☐ Stroke	_____
☐ Tuberculosis	_____