

Acupuncture Medical Group

www.acupuncturemedical.org

Tel: 603-531-3130

Name: _____ **Referred by:** _____

Address: _____

Phone (h): _____ **(w):** _____

Email: _____

Birthdate: _____ **Height:** _____ **Weight:** _____

Please fill out the following medical history questions as accurately as you can

What is your principal complaint: _____

What is the diagnosis (if any) by an MD: _____

Birth history (any medical procedures or medications?) _____

Vaccination history (any reactions to vaccines? Unusual vaccinations?) _____

Childhood Illnesses (0-12) any surgeries, accidents, major events? Please list in chronological order

Age: _____

Age: _____

Age: _____

Age: _____

Adolescence Illnesses (12-18) any surgeries, accidents, major events? Please list in chronological order

Age: _____

Age: _____

Age: _____

Age: _____

Adulthood Illnesses surgeries, accidents, major events? List in chronological order and indicate duration

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Family History: Please note all major illnesses in your immediate family (parents, grandparents), e.g., diabetes, heart disease, hypertension, neurological, blood, psychological, or orthopedic disorders, etc.

Are you taking any medications? Please note any medications even if you are taking them only occasionally. Also include medications taken in the past. (This includes birth control.)

Signature: _____ **Date:** _____