



# Eastside Family Acupuncture



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Name: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Are you currently using pharmaceutical drugs?  Yes  No If Yes, Please List: \_\_\_\_\_

Have you had Chinese Medicine before?  Yes  No

## FAMILY MEDICAL HISTORY

- |                                    |   |                                 |  |                                   |
|------------------------------------|---|---------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |                                   |

## YOUR PAST MEDICAL HISTORY (please check any that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Aids/HIV              | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Scarlet fever     | <input type="checkbox"/> Goiter                       |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Rheumatic fever              |
| <input type="checkbox"/> Appendicitis          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Surgeries         | <input type="checkbox"/> Pregnant at this time        |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Measles             | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Attempted suicide            |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Presently seeing a therapist |
| <input type="checkbox"/> Chicken pox           | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Typhoid fever     | <input type="checkbox"/> Whooping cough               |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Gout                         |
| <input type="checkbox"/> Polio                 | <input type="checkbox"/> Venereal disease    |  |   |
| <input type="checkbox"/> Other (specify) _____ |  |  |   |

## GAN (please check any that apply)

- |                                     |  |  |  |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Tinnitus          | <input type="checkbox"/> Spots in the eyes             |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Blurry vision     | <input type="checkbox"/> Constant irritability         |
| <input type="checkbox"/> Tremors    | <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Tics              | <input type="checkbox"/> Withered and brittle nails    |
| <input type="checkbox"/> Anger      | <input type="checkbox"/> Rib/Flank pain    | <input type="checkbox"/> Excessive sighing | <input type="checkbox"/> Feeling of tightness in chest |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Red Eyes          | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Feeling of lump in throat     |
| <input type="checkbox"/> Numbness   | <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Stroke            |  |

## GYNECOLOGICAL

Length of Period: \_\_\_\_\_ Days

Length of Cycle: \_\_\_\_\_ Days

Date of Last Period: \_\_\_\_\_

Age when Menstruation began \_\_\_\_\_

Age when Menopause began \_\_\_\_\_

Date and result of last Pap Smear \_\_\_\_\_

Flow:  Heavy  Light

Color:  Normal  Pale  Bright Red

I experience:

- |  |                                       |                                       |   |
|--|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Clots             | <input type="checkbox"/> PMS          | <input type="checkbox"/> Cramps       | <input type="checkbox"/> Pain relieved by passing Clots |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Amenorrhea   | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Irregular Menstruation         |
| <input type="checkbox"/> Uterine Fibroids  | <input type="checkbox"/> Vaginal Odor |                                       |   |

Number of Pregnancies \_\_\_\_\_  
 Number of Live Births \_\_\_\_\_  
 Number of Abortions \_\_\_\_\_

Number of Premature Births \_\_\_\_\_  
 Number of Miscarriages \_\_\_\_\_

PI (please check any that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Fatigue   | <input type="checkbox"/> Abdominal pain                    | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Worry                  |
| <input type="checkbox"/> Loss of appetite  | <input type="checkbox"/> Bloating                          | <input type="checkbox"/> Edema           | <input type="checkbox"/> Excessive saliva       |
| <input type="checkbox"/> Loose stools  | <input type="checkbox"/> Diarrhea                          | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Bleed or Bruise easily |
| <input type="checkbox"/> Flatulence  | <input type="checkbox"/> Heavy limbs                       | <input type="checkbox"/> Prolapse        | <input type="checkbox"/> Lack of taste          |
| <input type="checkbox"/> Vaginal discharge<br>( <input type="checkbox"/> Yellow or <input type="checkbox"/> White) | <input type="checkbox"/> Cloudiness of the head in morning |  |   |

XIN (please check any that apply)

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Stuttering             | <input type="checkbox"/> Red face            | <input type="checkbox"/> Easily startled             |
| <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Aphasia                | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Bitter taste in the morning |
| <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Incessant talking      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dream disturbed sleep       |
| <input type="checkbox"/> Phobias      | <input type="checkbox"/> Inappropriate laughter | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Excessive dreaming          |
| <input type="checkbox"/> Tachycardia  | <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mouth & tongue sores        |

SHEN (please check any that apply)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Lower back pain    | <input type="checkbox"/> Memory problems       | <input type="checkbox"/> Hot flashes                             | <input type="checkbox"/> Weakness of knees or ankles |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Infertility           | <input type="checkbox"/> Night sweats                            | <input type="checkbox"/> Black circles under eyes    |
| <input type="checkbox"/> Brittle bones      | <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Impotence                               | <input type="checkbox"/> Concentration problems      |
| <input type="checkbox"/> Edema              | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Hearing problems                        | <input type="checkbox"/> Chronic sore throat         |
| <input type="checkbox"/> Teeth problems     | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Increased Libido                        | <input type="checkbox"/> Decreased libido            |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Bedwetting            | <input type="checkbox"/> Low grade fever in morning or afternoon |  |

FEI (please check any that apply)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Acute cough         | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Weak voice    | <input type="checkbox"/> Excessive grief or sadness            |
| <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Sore throat          | <input type="checkbox"/> Yellow phlegm | <input type="checkbox"/> Bleeding from nose                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Frequent colds       | <input type="checkbox"/> White phlegm  | <input type="checkbox"/> Sinus problems                        |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of smell        | <input type="checkbox"/> Wheezing      | <input type="checkbox"/> Fullness in the chest                 |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Difficulty breathing while lying down |

WEI (please check any that apply)

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Hiccup   | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Belching                 |
| <input type="checkbox"/> Epigastric pain    | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Swelling or pain in gums |
| <input type="checkbox"/> Acid reflux        | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bleeding gums    | <input type="checkbox"/> Tiredness in morning     |

- Bad breath
- Vomiting of clear fluid

**DAN** (please check any that apply)

- Bitter taste
- Indecisiveness
- Stiff Neck
- Ear Infection
- Timidity
- Yellow complexion
- Fatty stools
- Lack of initiative

**DA CHENG** (please check any that apply)

- Constipation
  - Tenesmus
  - Fever
  - Burning sensation in mouth
  - Diarrhea
  - Itchy anus
  - Burning anus
  - Abdominal pain or distention
  - Black stools
  - Blood in stool
  - Rectal pain
  - Cold sensation in abdomen
- Number of bowel movements per day: \_\_\_\_\_

**PANG GUANG** (please check any that apply)

- Pain with urination
- Urgent urination
- Unable to hold urine
- Wake up to urinate often
- Frequent urination
- Blood in urine
- Incomplete urination
- Bladder or kidney stones

**LIFESTYLE HABITS** (please check any that apply)

- Alcohol
- Smoking
- Marijuana
- Eating disorder
- Hard drugs

Do you exercise?  Yes  No  
 If so, please describe:

**DIET**

Please give a brief description of what you eat daily:

Breakfast:

Lunch:

Dinner: