17305 Von Karman Ave., Suite 109
Irvine, CA 92614
(949) 679-8818 (Tel)
(949) 679-8819 (Fax)

GLOBAL HEALTH & SPORTS INSTITUTE

Yuanchun Jane Huang DAc.
Lee Furukawa D.C

Patient Medical Information & History

What is your chief complaint? ____

Do you have a tendency to faint? **Yes** **No** Are you H.I.V. positive? **Yes** **No**

Do you have a pacemaker? **Yes** **No** Have you ever had hepatitis? **Yes** **No**

Experience abnormal bleeding? **Yes** **No** Are you pregnant? **Yes** **No**

Have you had acupuncture before? **Yes** **No** If yes, when?________ For what condition were you treated?__________

Medication Info: Please list all current medication (add another sheet if need)

Start Date	Medication Name	Purpose/Indication	Dose	How Often	Last Date

Symptom History: (+) *Frequently experience* (›) *Sometimes experience* (*No Mark*) *Never experience*

Cardiovascular

___Heart Palpitations
___Shortness of Breath
___High Blood Pressure
___Chest Pain/Pressure
___Irregular Heartbeat
___Dizziness
___Leg Cramp
___Cold Hands/Feet

Respiratory

___Dry Cough
___Cough with sputum
___Cough with blood
___Sore Throats
___Nasal Problems
___Poor sense of smell
___Nose Bleeds
___Asthma/Wheezing
___Pneumonia
___Hay Fever
___Bronchitis
___Allergies
___Itchy Skin

Gastrointestinal

___Indigestion
___Bloating
___Gas/Belching
___Abdominal Cramps
___Gall Stones
___Constipations
___Diarrhea
___Blood in bowels
___Black/Tarry bowels
___Excessive Appetite
___Colitis/Diverticulitis
___Heartburn
___Acid Reflux
___Fatigue
___Edema/Swelling

Genitourinary

___Frequent Urination
___Painful Urination
___Bloody Discharge
___Venereal Disease
___Pain in Genital Area
___↑sex drive
___↓sex drive
___Kidney Stone
___Kidney Failure
___Neuritis

Musculoskeletal/Nervous

___Back Pain
___Neck Pain
___Arthritis
___Muscle Pain/Cramps
___Painful Joints
___Disc Problem
___Epilepsy
___Scoliosis

___Headache/Migraine

___Muscle Twitching

___Joint Tightness/Stiffness

___Soft/Brittle Nails

___Achy Bones

Skin

___Ulceration

___Rash

___Edema

___Eczema

___Psoriasis

___Herpes

___Acne

Males Only

___Prostate Problems

___Pain in Testicles

___Low Sperm Count

Females Only

___Pre Menstrual Pain

___Menstrual Pain

___Irregular Menstrual Cycles

___Swelling/Pain in Breast

___Lower Back/Sacrum pain

___Heavy Bleeding

___Excessive Vaginal Discharge

Miscellaneous

___Vision Problems

___Sensitivity to weather change

___Blood Clotting

___Itchy Eyes

___Poor Memory

___Ringing in Ears

___Memory Loss

___Hearing Loss

___Night Sweats

___Hair Loss

___Depression

___Insomnia

___Red Eyes

___Diabetes

___Cancer

___Chills

___Fever

OTHER:

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Energy Level	**(lowest)**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(highest)**
Stress Level	**(lowest)**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(highest)**
Pain Level	**(lowest)**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(highest)**

Please list all areas of pain: ____

____

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Initials:_____________ **Date:**______________