PETER SHENG, M.D.

PATIENT HISTORY

ACUPUNCTURE/Integrative Medicine

PATIENT NAME : _____

Weight _____ Height : _____

REASON VISITING THIS OFFICE : _____

_____

Past Medical History/Surgery

1. _____
2. _____
3. _____
4. _____
5. _____

Prescription Drugs

1. _____
2. _____
3. _____
4. _____
5. _____

Health History : Check all that apply

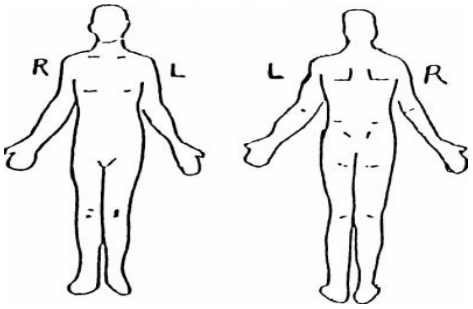
__ HIV __ Bleeding Disorder __ History of Fainting __ Taking Blood Thinners
__ Feeling Hot __ Feeling Cold __ Warmer at Night __ Night Sweats
__ Headache __ Sweats easily/profusely __ Cancer Site _____
__ Constipation __ Diarrhea __ Other Digestive Issues
__ Angina __ Heart Palpitation __ Shortness of Breath __ Thirsty
__ Frequent Urination __ Urination during Sleep __ Urine Yellow/Short __ Urine Long/Clear
__ Drink a Lot of Water

Female History : Check all that apply

__ Menopausal __ Still Menstruating __ Periods Regular __ Periods Early
__ Periods Late __ Pain with Menstruation __ Scanty Period __ Bleeding Excessively
__ PMS __ Infertility __ Polycystic Ovary __ Fibroids

*****Skip next section if you are not here for pain management. Sign at the bottom of the form.****

Please indicate where you have pains:



Description of Predominant Pain _____
_____
_____

Intensity {Scale 0 (no pain) – 10 (most intense)} _____

Duration & when occurs _____

Precipitating Factors _____ _____

Alleviating Factors _____

_____ _____
Patient Signature Date