

# PETER SHENG, M.D.

## PATIENT HISTORY ACUPUNCTURE/Alt Medicine

PATIENT NAME : \_\_\_\_\_

Weight \_\_\_\_\_ Height : \_\_\_\_\_

REASON VISITING THIS OFFICE : \_\_\_\_\_

Last seen by a physician When \_\_\_\_\_ Physician \_\_\_\_\_  
Reason \_\_\_\_\_

### Previous Hospitalizations

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_

### Previous Operations

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_

### Health History : Check all that apply

Hereditary Family Disease  Stroke  Lung Disease  Heart Disease  High Blood Pressure

Diabetes  Cancer Site \_\_\_\_\_

Do you have :  Cancer  Bleeding Problems  Heart Disease  High Blood Pressure

Diabetes  Cancer Site \_\_\_\_\_

HIV  Hepatitis

Are you on blood thinning medication?  Yes  No

Are you HIV positive?  Yes  No

Please List Any Other Health Problems You Have :

\_\_\_\_\_

Please List Any Prescription Medicine(s) That You are Presently Taking ( Name and Dosage)

\_\_\_\_\_

Do you drink  Tea  Coffee  Alcohol How Often ? \_\_\_\_\_

How often do you exercise ? \_\_\_\_\_

For Woman Only :

Are you pregnant ?  Yes  No

Number of Pregnancies \_\_\_\_\_ Number of Births \_\_\_\_\_

Your last gynecological Exam Date \_\_\_\_\_

Your last PAP smear Date \_\_\_\_\_ Result \_\_\_\_\_

\*\*\*\*CONTINUE PLEASE\*\*\*\*

In the last six months, which of the following symptoms have you experienced?

Check what applies

	Never	Sometimes	Often		Never	Sometimes	Often
Difficult to stop bleeding				Heart palpitations			
Swelling				Angina pains			
Excessive appetite				Mentally restless			
Digestion problems				Laugh for no apparent reason			
Vomiting				Insomnia, difficulty sleep			
Belching or burping				Nightmares			
Heartburn				Feeling of Claustrophobia			
Feeling of food retention				Easily angered or agitated			
Difficulty digesting oily foods				Spasms/twitching of muscles			
Loose stools or diarrhea				Fatigue			
Blood in stools				Jaundice			
Black tarry stools				Hepatitis			
Constipation				Skin problems			
Light colored stools				Gall stones			
Hemorrhoids				Bronchitis			
Cough				Soft/brittle nails			
Shortness of breath				Colitis or diverticulitis			
Decreased sense of smell				Eye problems			
Nasal problems				Easily bruised			
Resent use of antibiotics				Asthma			
Low back pain				Catch colds easily			
Sciatica				Intolerance to weather changes			
Knee problems				Allergies			
Hearing Impairment				Hayfever			
Ringing in ears				Faint easily			
Kidney stones				High blood pressure			
Decreased sex drive				High cholesterol			
Hair loss				Sudden weight loss			
Urinary problems							

Any related comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\*\*\*\*\* IF YOU DO NOT HAVE PAIN STOP HERE \*\*\*\*\*

