Qihuang Medical Group Corp.
5150 Graves. Ave. Ste 8D San Jose CA 95129

Patient Intake Form

Patient Name:_____**Age:**_____**Date of Birth:**___/___/___

Main problem(s): You would like treated_____

When did this problem begin?_____

What are the possible causes of current issue(s)?_____

Have you been given a diagnosis for this problem? If so, what?_____

To what extent does this problem interfere with your daily activities (work, sleep, etc.)?

_____

What kind of treatment(s) have you tried?_____

What makes this problem worse?_____

What makes it better?_____

Is there anybody in your family with the same/similar problem?_____

Recent Medical Tests or Procedures (please indicate test results and dates below)

Physical	Cholesterol	Prostate Exam	Blood Test
HIV/STD	Pap Smear	Mammogram	Other

Test Results and Date:_____

Past Medical History: (Please include month/year when the diagnose was established)

Significant illness: Cancer Diabetes Hepatitis Thyroid Dz Seizures
Fibromyalgia Arthritis TB Anemia Hypertension
Breathing Problems Heart Dz Digestive Disorder HIV/AIDS Positive
Veneral Dz Other (please specify):_____

Surgeries_____ **Hospitalization**_____

Significant trauma_____

Allergies_____

Family Medical History (Please specify family member)

Hypertension Heart Dz Stroke Asthma Alcoholism Cancer
Miscarriage Diabetes Other

Medicines: Taken within the last two months (Including vitamins, over the counter drugs, herbs,etc.)

_____

_____

Occupation

Do you usually work indoors outdoors ?

Any occupational stress (chemical, physical, psychological, etc.)_____

Personal

Height_____ Weight now_____ one year ago_____ Weight maximum at year_____

Habits

Do you smoke? Y/N What?_____ How many per day?_____ Since when?_____

If you are a smoker, do you want to quit? Y/N [Level of determination to quit- 1 2 3 4 5 6 7 8 9 10]

Please describe any use of drugs for non-medical purposes_____

Do you exercise regularly? Y/N Please describe your exercise program_____

How many hours do you sleep in general?_____When do you usually go to bed?_____

Diet

How much coffee do you drink?_____cups/day; Colas_____#/day; Tea_____cups/day_____

What kind of alcoholic beverages do you usually drink?_____ Average # of drinks/week_____

How much water do you drink per day?_____cups/day

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Y/N

Remarks and additional information (e.g. diet)_____

Please describe your average daily diet (Please be as specific as possible):

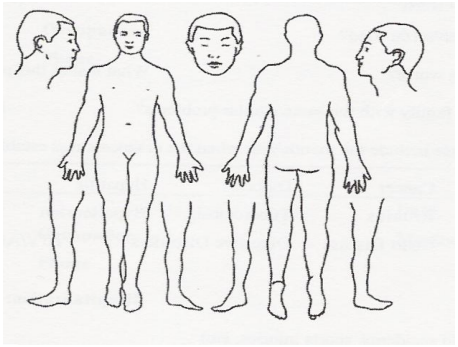
Morning_____

Afternoon_____

Evening_____

Snacks_____

Indicate painful or distressed area:



Rate no pain 0 1 2 3 4 5 6 7 8 9 10

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

Poor appetite | Poor sleeping | Fatigue | Fevers | Chills

Night sweats | Sweat easily | Tremors | Cravings | Change in appetite

Poor balance | Bleed or bruise easily | Localized weakness | Weight loss | Weight gain

Peculiar tastes | Desire for spicy food | Desire cold foods | Strong thirst (cold or hot drinks)

Sudden energy drop (what time of day)_____

Favorite time of year_____Worst time of year_____

Skin & Hair

Rashes | Ulceration | Hives | Itching | Eczema | Pimples | Dandruff

Dry skin | Recent Moles | Loss of Hair | Change of hair or skin textures | Other:

Musculoskeletal

Joint disorders | Muscle weakness | Pain/soreness in the muscles | Tremors

Difficulty walking | Cold hands/feet | Swelling of hands/feet | Back pain

Spinal curvature | Hernia | Numbness | Tingling

Paralysis | Neck tightness | Neck pain | Shoulder pain

Hand/wrist pain | Hip pain | Knee pain | Sprain of joint

Other:

Head, Eyes, Ears, Nose and Throat

Dizziness | Concussions | Migraines

Glasses/lens | Eye strain | Eye pain | Color blindness | Night blindness

Poor vision | Cataracts | Blurry vision | Spots in front of eyes

Earaches | Ringing in ears | Poor hearing | Sinus problems | Nose bleeding

Sore throat | Grinding teeth | Teeth problems | Sores on lips/tongue | Facial pains

Jaw clicks | Difficulty swallowing | Other:

Cardiovascular

High blood pressure | Low blood pressure | Chest pain | Palpitation | Fainting

Rapid heartbeat | Irregular heartbeat | Phlebitis | Varicose veins | Other:

Respiratory/LU

Persistent cough | Coughing blood | Wheezing | Difficulty breathing | Bronchitis

Nosebleeds | Sinus congestion | Sore throat | Chronic allergies | Asthma

Dry skin | Hives | Eczema | Grief | Emphysema

Pneumonia | Chest pain | Production of phlegm – What color?_____

Allergies to: Mold | Cedar | Dust | Pet Fur | Oak | Hay Fever | Grass | Environmentally sensitive

Gastrointestinal/SP-ST

Bloating Cravings Acid Reflux Fatigue after meals

Nausea Vomiting Diarrhea Constipation Gas Belching

Indigestion Black stools Blood in stools Bad breath Rectal pain Hemorrhoids

Abdominal pain/cramps Gallbladder problems Parasites Chronic laxative use

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/form_____

Accumulated Damp

Foggy mind Swollen hands/feet Edema in the legs Edema in the abdomen

Joint stiffiness/ache Symptoms worsen in rainy weather

Heaviness of the head, the limbs, or of the whole body

Neuro-psychological

Loss of balance Lack of coordination Concussion Depression Anxiety Stress

Bad temper Bi-polar

Genito-urinary

Pain on urination Frequent urination Blood in urine Urgent to urinate Kidney stones

Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection

Pain in genitals Itching of genitals Strong odor Other:

Female

Frequent vaginal infections Pelvic infection Endometriosis Fibroids Clots

Vaginal/genital discharge Ovarian cysts Breast tenderness Breast lumps

Irregular periods Pain/cramps prior/during periods Hot flashes

Moodiness related to periods Fertility problems ___# of pregnancies ___# of births ___Miscarriages

___Abortions ___Premature births ___Cesareans ___Difficult delivery

First day of last period_____ Age of first menses___ Duration of periods _____days, cycle_____days

Do you practice birth control? Y/N. If yes, what type and for how long?_____

If you are on birth control pills, what are you taking and for how long?_____

Male

Prostate problems Discharge Impotence Frequent seminal emission

Fertility problems Ejaculation problems Painful/swollen testicles Other

Both Normal High sex drive Diminished sex drive Infertility Fatigue following sex

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: _____ Adult Patient Parent or Guardian Spouse