



Valencie Exceus, AP, DOM

Acupuncture Physician, Doctor of Oriental Medicine
3500 N State Road 7 Suite 207
Lauderdale Lakes, FL 33319
954-390-0411

This is a CONFIDENTIAL questionnaire to help determine the best treatment for you. Please fill it out as completely as possible even if you do not fill certain questions pertain to your present condition.

PERSONAL INFORMATION

First Name _____ Last Name _____ Age ____ Today's Date _____

Home Address _____

City _____ State _____ Zip Code _____

Email _____ Date of Birth _____ Social Security _____

Cell Phone _____ Home Phone _____ Work Phone _____

Emergency Contact: Name _____ Contact Phone _____

How did you hear about us? _____

Have you been treated with acupuncture before? ____ Yes ____ No

If yes, Where and When? _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):

____ Hepatitis ____ HIV ____ High Blood Pressure ____ Seizures ____ Pacemaker ____ Blood-Thinning Medications ____ Pregnant

Please describe the reason for the visit today (The Chief Complaint) _____

How long have you had this condition? _____

What seems to be the initial cause? _____

What seems to make it worse? _____

What seems to make it better? _____

Does it affect your ____ Sleep ____ Work ____ Other (please list) _____

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

MEDICINES:

Prescription drugs you are currently taking:

For what condition?

Over-the-counter medication you are currently taking:

For what condition?

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name & address of physician _____

Phone number of physician _____

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes no when: _____ Length of cycle _____

Color of menstrual blood: pale bright red dark red brown other _____

Texture of menstrual blood: thick thin watery normal

Pain: yes no when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since menopause? _____

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

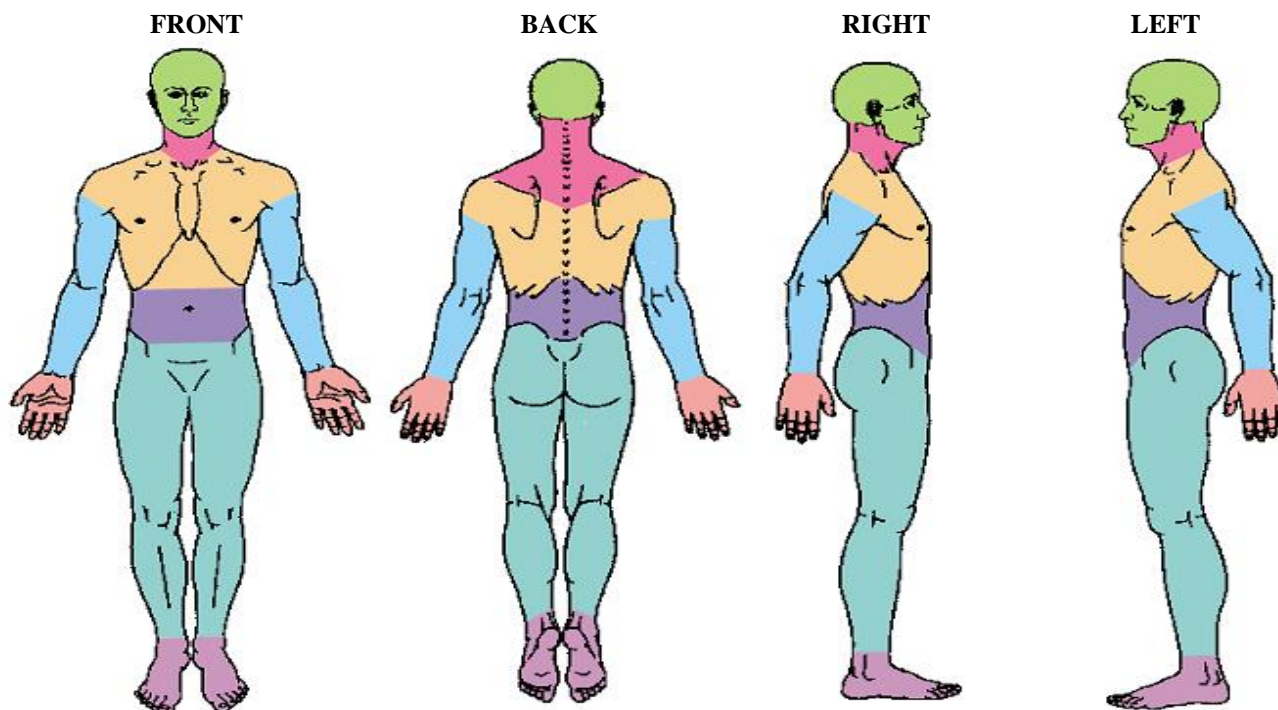
Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Other

PAIN PATIENTS ONLY

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you describe your pain: dull/achy sharp/stabbing burning tingling
 Throbbing Soreness numbness electrical other (please describe) _____

Please write down the area of pain and the pain level on a scale of 1 to 10, 10 being the highest level of pain.

_____	☺	1	2	3	4	5	6	7	8	9	10	☹
_____	☺	1	2	3	4	5	6	7	8	9	10	☹
_____	☺	1	2	3	4	5	6	7	8	9	10	☹

MEN ONLY

Date of Last Prostate Check up _____ PSA result _____
 Digital Rectal Exam Result _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Reduced Libido | <input type="checkbox"/> Excessive Libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Genital/ Testicular pain |
| <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Groin Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Retention of Urine | <input type="checkbox"/> Incontinence |

Frequency of urination: daytime ____ nighttime ____ Urine Odor _____

Color of urine Clear Murky Dark Yellow Blood in the urine

PLEASE SIGN THE COMPLETED FORM

Name _____ Patient's Signature _____ Date _____
Print
 If under 18: Name of parent or legal guardian _____ Signature _____