Print Form

Mt. Airy Community Acupuncture Center

Brief Health History Form
(to be filled out on your first visit)

Patient Name: _____ Birth Date: _____ Age: _____

Western diagnosis, if known: _____

Is there any procedure or surgery scheduled for you? ☐ Yes ☐ No If yes, when? _____

Medical History:

☐ Asthma ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Chronic Pulmonary Disease

☐ Kidney Disease ☐ Liver Disease ☐ Bleeding disorder ☐ Thyroid Disease ☐ Seizures

☐ Hepatitis ☐ Depression ☐ Anxiety ☐ High Stress Level ☐ Alcoholism

☐ Cancer – what kind?_____ ☐ Other (specify)_____

Any other info you would like us to know about your health history:

_____

_____

_____

Allergies: ☐ None ☐ Yes If yes, please specify_____

Current Medications: ☐ None ☐ Yes If yes, please specify_____

_____

Social History: ☐ Alcohol ☐ Tobacco

Significant Trauma (auto accidents, falls, etc.)_____

_____

Significant Surgical History: ☐ None ☐ Yes If yes, please specify_____