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Patient Health History Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information clearly and indicate areas of confusion with a question mark.

I. General Patient Information:

Today's Date: ____/____/____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ lbs

Gender: M F Marital Status: S M D W

Occupation: _____

Phone #: Home: _____ Work: _____ Cell: _____

Email Address: _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Primary Physician Name: _____

Address: _____ Phone: _____

II. Current Medical History:

Are you currently under the care of a physician? Y N If yes, for what? _____

Please indicate health concerns that have brought you to Dr. Burgoon, in order of importance:

Condition A: _____

How long have you had this condition? _____

How did it start? _____

What treatments have you received? _____

What seems to make it better? _____

What seems to make it worse? _____

Condition B: _____

How long have you had this condition? _____

How did it start? _____

What treatments have you received? _____

What seems to make it better? _____

What seems to make it worse? _____

Condition C: _____

How have you had this condition? _____

How did it start? _____

What treatments have you received? _____

What seems to make it better? _____

What seems to make it worse? _____

Foods, drugs, or medications you are hypersensitive or allergic to (please indicate reaction):

Dietary restrictions: _____

Food cravings: _____

Medications (prescribed & over-the-counter), vitamins, & supplements you currently take:

Name	Dose	Purpose	How long?

Do you have any reason to believe that you are currently pregnant? Yes No

Due date: _____

III. Family History:

Please list any medical conditions, disorders or diseases of a hereditary nature in your family, such as cancer, diabetes, heart disease, high blood pressure, mental illness, asthma, etc.:

IV. Past Medical History:

Childhood Illnesses (Circle any that apply):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other: _____

Immunizations (Circle any that apply):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Other: _____

Hospitalizations and Surgeries:

Reason	When?	Reason	When?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

X-Rays/CAT Scans/MRIs/NMRs/Special Studies:

Reason	When?	Reason	When?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. Patient Profile:

General Symptoms (Check any that currently apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor/Heavy Appetite | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Recent Weight Loss/Gain | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Bruise/Bleed Easily |
| <input type="checkbox"/> Tired after Eating | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Lack of Strength |
| <input type="checkbox"/> Frequent Thirst | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Strong like for Hot/Cold Drinks | <input type="checkbox"/> Poor Sleep/Insomnia | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dream-disturbed Sleep | Other: _____ | |

Head, Eyes, Ears, Nose, Throat (Check any that currently apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Teeth/Gum Problems | <input type="checkbox"/> Excessive Phlegm |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> TMJ/Jaw Problems | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Red/Itchy Eyes | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Tearing/Dry Eyes | <input type="checkbox"/> Earaches | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Glaucoma | Other: _____ | |

Respiratory (Check any that currently apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Difficulty Inhaling/Exhaling | <input type="checkbox"/> Wet/Dry Cough | <input type="checkbox"/> Cough with Phlegm |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Color of Phlegm |
| <input type="checkbox"/> Asthma | Other: _____ | |

Cardiovascular (Check any that currently apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Varicose Veins |
| Other: _____ | | |
-

Gastrointestinal (Check any that currently apply):

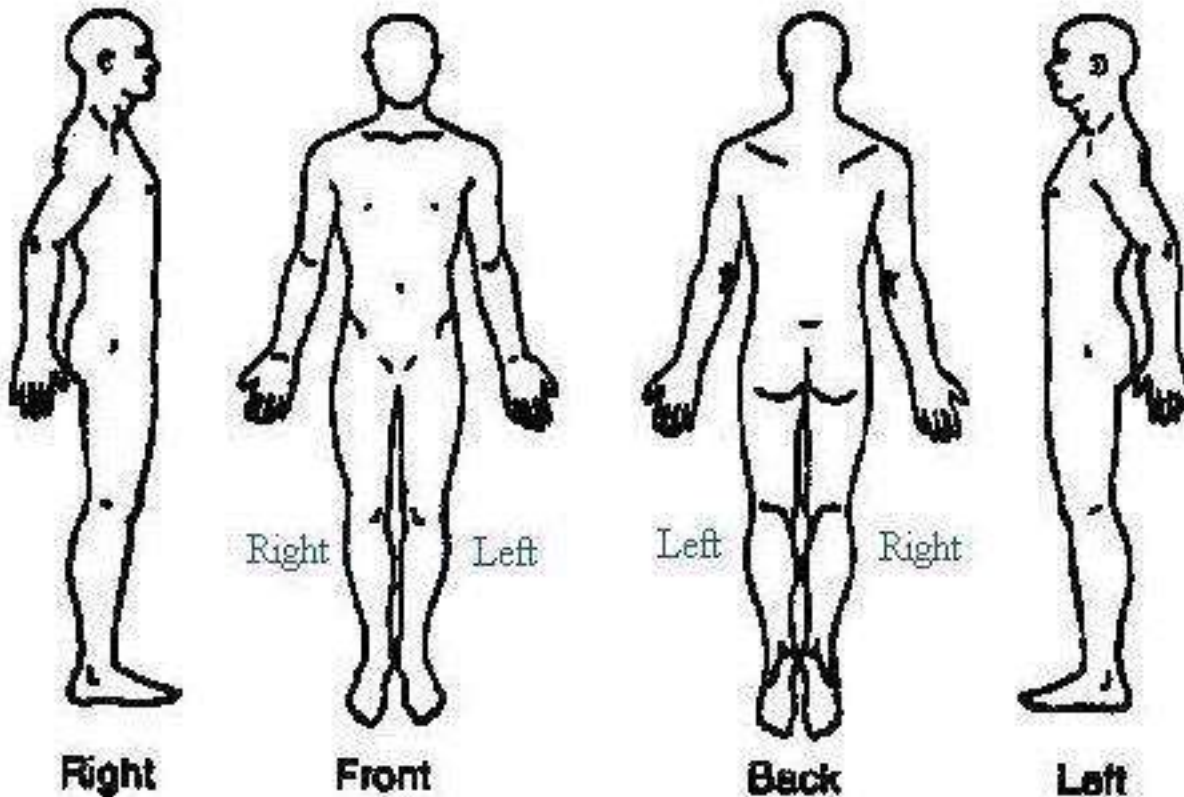
- | | | |
|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Gas/Flatulence | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bloating/Distention | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid Reflux/Heartburn | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Mucus/Blood in Stools |
| <input type="checkbox"/> # of Bowel Movements/Day | Other: _____ | |

Endocrinal (Check any that currently apply):

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Feeling Hot/Cold |

Musculoskeletal

On the following diagram, shade in the areas that you feel should be addressed:



Describe the location of your pain/tenderness/tightness: _____

The pain is (check all that apply): _____

Dull Sharp Stabbing Aching Numb Burning Deep
 Tingling Superficial Comes/Goes Other: _____

Circle, as applicable:

Pain is Worse/Better with Heat

Pain is Worse/Better with Cold

Pain is Worse/Better with Pressure

Pain is Worse in the Morning/Evening

Pain is Worse/Better with Rest

Pain is Worse/Better with Movement or Activity

I have (check all that apply):

Swollen Joints Arthritis Joint Pain Tendonitis Rheumatism Bone Pain
 Muscle Cramping Muscle Pain Repetitive Sprain Injury Other: _____

Genito-Urinary Tract (check all that currently apply):

Painful Urination Urgent Urination Wake to Urinate
 Frequent Urination Blood in Urine Difficulty Urinating
 Frequent UTIs Other: _____

Hair and Skin (check all that currently apply):

Rashes/Hives Itching Dandruff
 Loss of Hair Unhealed Sores Eczema
 Change in Hair or Skin Texture Other: _____

FEMALES: Gynecological (check all that currently apply):

Infertility Breast Tenderness Irregular Periods
 Painful Periods Vaginal Discharge Bleeding between Cycles
 PMS Heavy Flow Menopausal Symptoms
 Clotting Other: _____

FEMALES: Menstrual/Birthing History:

Age of First Menses: _____ # of Pregnancies: _____
of Days of Menses: _____ # of Miscarriages: _____
Length of Cycle: _____ # of Abortions: _____
Birth Control Type: _____ # of Live Births: _____
Age of Menopause: _____ # of Children: _____

FEMALES: Do you experience any pre-menstrual syndrome (PMS), such as migraines/headaches, tender breasts, water retention, food cravings, irritability, depression, joint/muscle pain?

Explain: _____

MALES: Reproductive System (check any that currently apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Swollen Testes | <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Feeling of Cold in External Genitalia | <input type="checkbox"/> Feeling of Numbness in External Genitalia | |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Nocturnal Emissions | <input type="checkbox"/> Sexual Difficulties |

Other: _____

Neuropsychological (check all that currently apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mental Tension |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Dyslexia |

Fatigue Other: _____

Lifestyle, Exercise, Diet, & Energy:

Describe your Level of Energy: _____

What Time of the Day is your Energy the Highest? _____ Lowest? _____

Do you Fatigue Easily? Yes No What Makes you Tired? _____

What Type of Exercise do you do and How Often? _____

Do you: Smoke Cigarettes Smoke Marijuana Smoke Cigars Drink Alcohol Other

If Yes, How Often? How Much? _____

Describe your Typical Sleeping Patterns: _____

How Many Hours/Night do you Sleep? _____

Do you Wake to Urinate? Yes No How Many Times? _____ At What Time? _____

Do you Wake up Rested? _____

Do you Have Difficulty: ____Falling Asleep ____Staying Asleep

Do you Snore? Yes No

Do you Typically eat 3 Meals per Day? Yes No If No, How Many: _____

Describe your Appetite and Cravings: _____

Eat Meat? Yes No Frequency: _____

Eat Sugar? Yes No Frequency: _____

Eat Dairy? Yes No Frequency: _____

Average Daily Menu (Indicate times and types of things you eat):

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Nighttime Snack _____

How did you hear about Medical Acupuncture of Chester County?

If referred, name? _____