PRINCETON MEDICAL ACUPUNCTURE CENTER PROFESSIONAL LLC

# Patient Medical History Form

| Name | Date of Birth | Occupation |
|---|---|---|
| Street Address | City | Zip Code |
| Home Phone # | Mobile Phone # | Subscriber (Name & Date of birth) |
| Main Problem(s) | Date of Onset | Email Address |

**PLEASE ANSWER THE FOLLOWING**

Height: ______________ Weight: ______________ Are you pregnant? (Female Patient) ______________

Do you have a pacemaker: ______________

**PAST MEDICAL HISTORY**

| | Yes | No |
|---|---|---|
| Are you pregnant?.......................... | ☐ | ☐ |
| Do you have a pacemaker............ | ☐ | ☐ |
| Are you taking blood thinners......... | ☐ | ☐ |
| Cancer......................................... | ☐ | ☐ |
| High blood pressure...................... | ☐ | ☐ |
| Diabetes....................................... | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Arthritis.......................................... | ☐ | ☐ |
| Heart disease................................ | ☐ | ☐ |
| HIV................................................. | ☐ | ☐ |
| Hep B............................................. | ☐ | ☐ |
| Hep C............................................. | ☐ | ☐ |

Accidents/Injuries ______________________ Other ______________________

Surgeries (specify with dates) ______________________________________________

Medicines/therapies received in the past 3 months

______________________________________________________________________

**Habits:**

| | Yes | No |
|---|---|---|
| Cigarettes/Cigars.......................... | ☐ | ☐ |
| Alcohol.......................................... | ☐ | ☐ |
| Drugs............................................. | ☐ | ☐ |

**Family History: (If yes specify whom-**

| | No | Yes | Mother | Father | Sister | Brother | Children |
|---|---|---|---|---|---|---|---|
| Cancer..................... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease............ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High blood pressure... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke....................... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alcoholism................ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies/asthma....... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Diet/Nutrition** ______________________ **Physical Activities** ______________________

______________________________ ______________

**Patient Signature** **Date**