Alvaro Toledo, Acupuncture Physician
Gainesville Acupuncture & Holistic Medicine
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PATIENT INFORMATION

Name_____ Date_____

Home Address_____

City_____ State_____ Zip_____

Email Address_____ Phone_____

Occupation_____

Place of Birth_____ Date of Birth_____

Age_____ Height_____ Sex_____

In Case of Emergency Notify_____

How did you hear about this office?_____

Have you ever before tried acupuncture or Chinese herbal medicine?_____

CHIEF COMPLAINT

What are the main health problems for which you are seeking treatment?

_____

_____

Please rate the extent to which your current complaint affects your daily life
(1=minor; 10=major)_____

Please rate your commitment to resolving this problem _____

What other forms of treatment have you sought? _____

_____

PAST MEDICAL HISTORY
(circle all which apply)

Allergies	Cancer	Diabetes	Hepatitis
High Blood Pressure	Heart Disease	Seizures	Rheumatic Fever
Surgeries	Venereal Disease	Thyroid Disease	Birth Trauma
Vaccinations	Childhood Illnesses	Accidents	Significant Trauma
Medications	Other (please specify) _____		

FAMILY MEDICAL HISTORY
(Circle all which apply and specify which blood relative)

Cancer	High Blood Pressure	Hepatitis	Diabetes
Infectious Disease	Rheumatic Fever	Heart Disease	Seizures
Emotional Disorder	Tuberculosis	Seizures	

Other (please specify) _____

LIFESTYLE
(Please indicate the use and frequency of the following)

Coffee	Black Tea	Tobacco
Alcohol	Caffeinated Beverages	Recreational Drug
Exercise	Other (please specify) _____	

MEDICATIONS

Please list any medications and/or supplements you are currently taking

_____

_____

ALLERGIES

_____

_____

GENERAL HEALTH
(Please circle all that apply)

Poor Appetite	Fatigue	Cold Hands/Feet	Tremors
Strong Thirst	Poor Balance	Cravings	Soft/Brittle Nails
Disturbed Sleep	Poor Coordination	Night Sweats	Large Appetite
Weight Loss	Bruise/Bleed Easily	Chills	Catch Colds Easily
Insomnia	Weight Gain	Cold Abdomen	Localized Weakness
Fevers	Sweat Easily	Sudden Energy Drop	

Other (please specify) _____

MUSCULO-SKELETAL

Neck Pain	Back Pain	Knee Pain	Muscle Pain
Foot/Ankle Pain	Shoulder Pain	Hip Pain	Hand/Wrist Pain
Sciatica	Muscle Weakness		

Other (please specify)_____

SKIN AND HAIR

Rashes	Ulcerations	Psoriasis	Pimples
Itching	Redness	Hair Loss	Recent Moles
Dandruff	Eczema	Hives	

Other (please specify) _____

HEAD, EYES, EARS, NOSE, THROAT

Dizziness Eye Pain Blurred Vision Floaters Spots in Eyes

Night Blindness Ringing in Ears Poor Hearing Earaches

Earaches Headaches Migraines Recurrent Sore Throat Jaw Clicking

Sores on Lips/ Tongue Dry Mouth/Face Facial Pain Bleeding Gums

Other (please specify) _____

RESPIRATORY

Cough Coughing Blood Asthma Bronchitis Pneumonia

Coughing Phlegm Pain with Deep Breath Shortness of Breath

Nasal Congestion Difficulty Breathing when Lying Down

Other (please specify) _____

GASTROINTESTINAL

Nausea Vomiting Diarrhea Constipation Gas Bloating

Belching Abdominal Pain/Cramps Indigestion Heartburn/Reflux

Retention of Food in Stomach Lack of Appetite Excessive Appetite

Rectal Pain Black Stools Blood in Stool Hemorrhoids Bad Breath

Sensitive Abdomen Chronic Laxative Use

Other (please specify) _____

GENITO-URINARY

Pain on Urination Frequent Urination Blood in Urine Urgency to Urinate

Kidney Stones Impotence Sores on Genitals Unable to Hold Urine

Decrease in Urine Flow Waking at Night to Urinate

Other (please specify) _____

CARDIOVASCULAR

Dizziness Low Blood Pressure High Blood Pressure Fainting

Chest Pain Irregular Heartbeat Cold Hands/Feet Blood Clots

Palpitations Swelling of Hands/Feet Difficulty Breathing

Other (please specify) _____

REPRODUCTIVE/GYNECOLOGICAL

Age of First Period _____ Age at Menopause _____ # Pregnancies _____

Live Births _____ # Premature Births _____

of Days Between Periods _____ # Days of Flow _____ Color of Blood _____

Clots Painful Menses Irregular Menses Premenstrual Symptoms

Strong Menstrual Odor Vaginal Discharge Vaginal Odor

Fibroids Vaginal Dryness Breast Lumps/Swelling Endometriosis

Ovarian Cysts Sexually Transmitted Disease Urinary Tract Infection

Hot Flashes Decreased Sex Drive Positive Mammogram/Pap Smear

Other (please specify) _____

NEURO-PSYCHOLOGICAL

Seizures Dizziness Loss of Balance Poor Memory

Areas of Numbness Lack of Coordination Concussion Depression

Anxiety Bad Temper Easily Stressed Attempted Suicide

Treated for Emotional Problems

Other (please specify) _____