Dr. Sharon Johnson-Eby, L.Ac., DCM
Ān Medi-Zen LLC

Patient Information

Name_____Date_____
Address_____
City_____State_____
Zip_____

Home Phone_____
Other_____
Work Phone_____
Fax_____
Email_____

Sex: male ( ) female ( ) trans ( ) other ( ) non-binary ( )
Pronouns: He/Him She/Her They/Them, or_____

Height_____ Weight_____

Birthdate_____/_____/_____

Age_____

Emergency Contact:

Name_____Phone_____
Referred by_____

Your primary doctor's contact information:
Name_____
Address_____
Phone_____Fax_____

Please indicate any significant illness you or a blood relative have had:

	Self/Relative	When?
Cancer		
Hepatitis		
High cholesterol		
High Blood Pressure		
Seizures		
Diabetes		
Emotional disorders		
Heart/Cardiovascular Disease		
Lung/Respiratory Disease		
Kidney Disease		
Infectious Disease		
Tuberculosis		
HIV/AIDS		

Health History

Please list any medications and supplements you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	How long	Prescribed by	Last check up

Please check if any of the following statements are true for you.

( ) I have known allergies ( ) I am taking anticoagulants ( ) I have a pacemaker ( ) I am pregnant

Please indicate the use and frequency of the following:

	Yes/No	How much/Frequency
Coffee/Black tea		
Water intake		
Soda pop		
Non-medical drugs		
Alcohol		
Tobacco		

How do you FEEL about the following areas of your life: Good Average Poor

	Good	Average	Poor
Significant other			
Family			
Diet			
Sex			
Self			
Work			
Exercise			
Spirituality			

Your comments:

_____

_____

_____

_____

_____

_____

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

_____

_____ What other forms of treatment have you sought?

_____

_____ Please list any other health problems you now have:

_____

_____ Please list any allergies or food sensitivities you may have:

_____

_____ Please list any accidents, surgeries or hospitalizations (including date):

_____

_____ Please list any special considerations or circumstances you would like your practitioner to be aware of:

_____

Have you received acupuncture before? Yes ( ) No ( )

Health History
For Men

Date of last prostate checkup_____/_____/_____
PSA results_____
Manual prostate exam
results_____
Frequency of urination: Daytime ____Night time____Color of urine: Clear ( ). Cloudy ( ). Red ( ). Odor ( )
Symptoms related to prostate:
Delayed stream ( )Dribbling ( )Rectal dysfunction ( )Increased libido ( ). Impotence ( ). Groin pain ( ).
Incontinence ( )Decreased libido ( )
Testicular pain ( )
Retention of urine ( )
Premature ejaculation ( )
Back pain ( )
Other: ( )
_____
_____

Health History
For Women

Age of first period (menarche)_____
Age of last period (menopause)_____
Number of days between periods_____
Number of days of flow_____
Number of pads/tampons on heaviest day_____
Color of flow: Red( ). Purple( ). Dark( ). Brown( ). Clots: yes( ) no( )
Are you pregnant? yes ( ). no ( )
Number of pregnancies_____ Number of live births_____
Number of abortions_____
Number of miscarriages_____
Date of last: Gynecological exam_____
Pap smear_____
Mammogram_____ Results _____
Have you been diagnosed with: Fibroids( ). Fibrocystic breasts ( ). Endometriosis ( ). PID ( ).
Ovarian cysts ( ). Other ( ).
Symptoms associated with menses:
Pain ( ). Nature of pain: Cramping ( ). Stabbing ( ). Burning ( ). Aching/dull ( ). Constant ( ).
Intermittent ( ). Bearing down sensation ( ).
Discharge ( ). Nature of discharge: Clear ( ). White ( ). Yellow ( ). Other color ( )_____
Thick ( ). Thin ( ). Scanty ( ). Copious ( )
Headache ( )
Swollen breasts ( )
Mood swings ( )
Irritability ( )
Decreased libido ( )
Hot flashes ( )
Increased libido ( )
Nausea ( )
Diarrhea ( )
Constipation ( )
Vaginal Dryness ( )
Night sweats ( )
Ravenous appetite ( )
Poor appetite ( )
Insomnia ( )
Other: ( )

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