Acupuncture Associates of Andover
90 Main Street
Andover, MA. 01810
www.moganacupuncture.com 617-823-3733

Acupuncture Associates of Boston
575 Boylston Street, 4th floor
Boston, MA. 02453
williammogan@yahoo.com

COMPREHENSIVE ACUPUNCTURE EXAMINATION

Note: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

NAME ______________________________ DATE ______________
Street ______________________________ City/ST/Zip ______________
Mobile ______________ Other phone ______________ Email Address ______________
Birth Date ______________ Height _ Weight ________ Occupation ______________

Major Complaints

1. ______________________________ Date of onset ______________
What makes it better? ______________________________
What makes it worse? ______________________________
Is your condition: __getting worse __constant __getting better __comes and goes

2. ______________________________ Date of onset ______________
What makes it better? ______________________________
What makes it worse? ______________________________
Is your condition: __getting worse __constant __getting better __comes and goes

3. ______________________________ Date of onset ______________
What makes it better? ______________________________
What makes it worse? ______________________________
Is your condition: __getting worse __constant __getting better __comes and goes

Other Complaints ______________________________
____

Medication: *Prescription and OTC medications* ______________________________
____

Supplements: *all vitamins, herbs, etc. that you are currently taking* ______________________________
____

List surgeries/operations *you have had and dates:* ______________________________

SCARS: *(List ALL scars from accidents or surgeries):* ______________________________
____

Date of your last physical examination? ______________ *By whom?* ______________________________

MEDICAL HISTORY: *(Do you have or have you ever had):* __Arthritis __Asthma __Anemia __Heart trouble __Cancer __Diabetes __Epilepsy __Stroke __Kidney or Bladder trouble __Gallstones __Ulcers __High blood pressure __Chronic fatigue __Hepatitis __Jaundice __Sudden weight loss __Sudden weight gain
Other ______________________________
ENERGY LEVEL: __HIGH (Time of day) ______________ Low (Time of day) ______________
STRESS: __None __Moderate __Severe. What causes it? ______________________________
SWEATING: __Night sweats __Rarely sweats __Excessive sweating ______________________________
CIRCULATION: Feelings of __ Hot __ Cold. What area/s? ______________________________

__Bleed easily __Cold limbs __Other ___

SKIN: __Dry __itchy __Moist/clammy __Burning __Changing moles or lumps (cysts/tumors) __Boils __Frequent skin rashes __Acne __Hair Loss/ thinning __Dry scalp __skin puffy/wrinkled __Bruises easily (black and blue spots) __Hives __Other ___

SLEEP: __Trouble falling asleep __Trouble staying asleep __Restful __Excessive dreaming ___
Other: ___ How many hours do you sleep a night? ___

HEAD: Headaches (What areas?) ___ _Dizziness _Memory loss _Loss of balance ___
Other: ___

EYES: _Eye pain _Dry eyes _Blurred vision _Darkness under eyes _Other ___

EARS: _Poor hearing _Earaches _Ear discharge/infections _Tinnitus (ringing/buzzing in ears) _Other ___

NOSE: _Frequent nose bleeds _Sinus trouble/infections _Frequent colds _Other ___

ALLERGIES: ___

THROAT: _Sore throat _Hoarseness _Difficulty swallowing _Jaw problems (grinding or TMJ) _Teeth/gum problems
_Swollen tongue/glands _Other: ___

LUNGS: _Asthma _Wheezing _Shortness of breath _Mucus rattles when breathing _Trouble breathing at night ___
_Frequent cough/chest colds _Pneumonia _Persistent cough _Coughing phlegm _Other ___
Cigarettes/Tobacco _Yes _No Amount per day? _How long? ___

HEART: _Heart attack _Stroke _Chest pain/pressure _Palpitations ___
Other ___

BLOOD PRESSURE: _High _Low _Normal _Do not know. ___

CHOLESTEROL: _High _low levels ___

APPETITE: _Normal _Excessive appetite _Poor appetite _Appetite keeps changing _Feel tired/weak if a meal is missed
Food cravings _No _Yes If yes, what? ___
Recent weight changes ___ Other: ___

NUTRITION: Do you _Skip breakfast _Eat a snack _Eat a hearty breakfast. How many meals a day do you eat? ___
When is your biggest meal? ___ Do you eat when worried or rushed? _Yes _No How often? ___
List some of your favorite foods. ___

THIRST: _Normal _Excessive _Never Thirsty Other: ___
Water: How much per day? ___ Caffeine: How much per day? ___
Alcohol: _No _Yes Amount per week? ___ Type? ___

DIGESTION: _Acid reflux _Belching _Stomach pain or bloating _Gas _Nausea _Vomiting _Bad breath _
_Mouth sores _Bitter/sour taste in mouth _Abdominal bloating _How long after eating? ___
Food Allergies _No _Yes If yes, to what? ___
Other ___

BOWELS: _Diarrhea _Constipation _Bloody stools _Black stools _Mucus in stools _Hemorrhoids _Lower bowel gas
_stools have foul odor _Colon problems Number of bowel movements per day? ___
Other ___

URINE: Color ___ times per day (6 is considered average) ___ _Frequent urination _Strong smelling urine
_Difficult to urinate _Pain or burning when urinating _Blood in urine _Frequent infections (bladder/UTI/Kidney) _Water retention
Other ___

MUSCULOSKELETAL: Pain in: _Neck _Shoulder _Between Scapulas _Arms/Hands _Fingers _Hip _Knee _Ankles
_Feet _Toes _Upper Back _Middle Back _Lower Back _Bones sore/painful _Loss of grip _Swollen knees/elbows
_leg cramps at night _weakness in legs _Weak ankles _Stiff all over _Tingling in feet _Muscle spasms/cramps
_Loss of feeling in hands/feet _Painful joints _Bursitis Other ___

NEUROLOGICAL: _Nervousness _Depressed _Easily angered _Easily irritated _Frequent crying _Worry/anxiety
_Panic attacks _Mood swings _Memory confusion _Poor concentration _Suicidal _Tremors _Numbness in limbs
_Poor coordination _Muscle weakness _Feel weak and shaky _Seizures _Neuralgia (nerve pain) _Shingles
Other ___

FEMALES: Pregnant _Yes _No Last monthly cycle ___ Last PAP test ___
Form of birth control: _None _Pill Other: ___
Age started menstrual cycle ___ Age stopped ___ Length of cycle ___ _Irregular _Menstrual pain
_Low backache _Clotting _Heavy bleeding _Light/scanty bleeding _Color ___ _Bloating _Mood changes

_ Miss periods _ Low or no sexual drive _ Painful breasts _ Hot Flashes _ Food cravings Other ______________________________
____
Discharges: _ Yellow _ Thick _ White _ Odor _ Itching _ Liquid _ Other ____
Number of Pregnancies ______ Number of Deliveries ______ Number of Miscarriages __ Number of Abortions ______________________
MALES: _ Low sexual drive _ Lack of sexual drive _ Impotence _ Ejaculation causes pain _ Discharge
_ Pain or burning while urinating _ Premature ejaculation _ Difficulty starting or stopping urine _ Prostate trouble
Other ____

Patient signature ____ Date ______________________________