Andrew Wu 吳奇
Center for TCM 中醫診療院

Medical History Questionnaire

Patient Name 姓名:_____ Today's Date 日期:_____

Have you ever had acupuncture or Chinese herbs before? ☐ Acupuncture 针灸 ☐ Herbs 药
你曾经有过针灸或服用过中药吗？

Your Complaints: 您的主诉:	**Diagnosis or Symptoms 诊断或症状**	**Duration of Condition 起病后持续的时间**	**Severity of Condition(1-9) 严重程度（1-9）**
Chief Complaint 第一主诉			
Secondary Complaint 第二主诉			
Additional Complaint 其他的症状			
Additional Complaint 其他的症状			

What do you think caused your condition?
你认为是什么造成你的病情现状？

_____

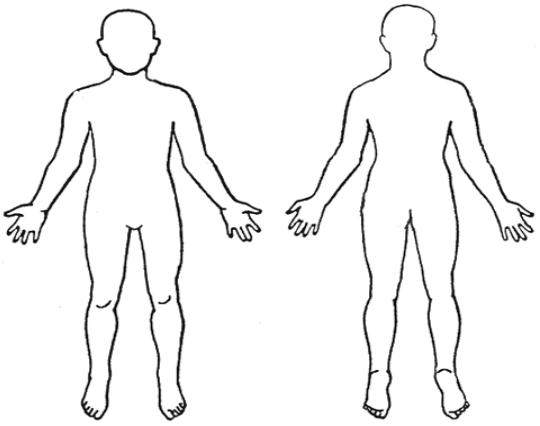
What makes your condition worse (sitting, eating, cold, etc.)?
是什么让你的病情恶化（坐，吃，冷等）？

_____

Have you had treatment elsewhere for your condition? ☐ Yes ☐ No
您是否为此病去过其他的诊所接受治疗？
If so, please describe what type of treatment and duration of treatment:
如果是的话，请说明是什么类型的治疗和治疗时间：

_____

Please Indicate Discomfort on Body
请标出不舒服的地方



Front 前 Back 后

Family Health History(Cancer, Heart Disease, Diabetes, etc) 家族健康史（癌症，心脏病，糖尿病等）	**Which Family Member? 请指出是何家庭成员呢?**

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Previous Serious Illness or Major Surgeries 曾有过任何严重的疾病或重大手术	Dates 日期

Prescription Medicines/ Supplements 处方药/营养补充品	Condition Treated/ Reason for Taking 治疗何病/为何用此药

Any other concerns you would like to discuss 你想讨论的任何其他问题吗？

Please Check All That Apply 请检查所有适用:

- ☐ Currently Under High Stress ☐ 目前处在高度精神压力下
- ☐ Digestion Issues (appetite, bowels) ☐ 消化问题（食欲，大便）
- ☐ Frequently Go To Bed Late ☐ 经常很晚才睡
- ☐ Body Easily Hot/Cold (Circle One) ☐ 身体容易热/冷（请圈出一个）
- ☐ Heavy Chest/Difficulty Breathing ☐ 胸闷/呼吸困难
- ☐ Poor Quality of Sleep ☐ 睡眠质量差
- ☐ Excess Sweating In Daytime or Night ☐ 在白天或夜间过量出汗
- ☐ Mouth Dryness ☐ 口干
- ☐ Poor Diet/Exercise ☐ 不良的饮食习惯
- ☐ Unexplained Weight Loss ☐ 不明原因的消瘦
- ☐ Hearing Issues (Tinnitus, Deafness) ☐ 听力问题（耳鸣，耳聋）
- ☐ Little/No Exercise ☐ 少量/没有锻炼
- ☐ Frequent Headaches ☐ 经常头痛
- ☐ Easily Tired or Low Energy ☐ 容易疲倦或能量很低
- ☐ Excessive Hair Loss ☐ 过度脱发
- ☐ Unexplained Pains ☐ 不明原因的疼痛
- ☐ Seasonal or Food Allergies ☐ 季节性或食物过敏
- ☐ (Female) Irregular/Painful Period ☐（女）不规则/疼痛的月经

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