PRINCETON MEDICAL ACUPUNCTURE CENTER PROFESSIONAL LLC

Patient Medical History Form

Name	Date of Birth	SS#
Street Address	City	Zip Code
Home Phone #	Mobile Phone #	Spouse Name & DOB
Main Problem(s)	Date of Onset	Email Address
Insurance Name	Insurance ID number	Insurance subscriber name

PLEASE ANSWER THE FOLLOWING

Height:________________Weight: ________________ Are you pregnant? : ________________

Do you have a pacemaker:________________Are you taking blood thinners: ________________

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____

Do you use alcohol? **YES** ☐ **NO** ☐ Do you snoke? **YES** ☐ **NO** ☐

Do you use drugs ? YES ☐ NO ☐

Family History: (if yes specify whom-

	Yes	No	Mother	Father	Sister	Brother	Children
Cancer………………	☐	☐	☐	☐	☐	☐	☐
Heart Disease………	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure.	☐	☐	☐	☐	☐	☐	☐
Stroke…………………	☐	☐	☐	☐	☐	☐	☐
Alcoholism…………	☐	☐	☐	☐	☐	☐	☐
Allergies……………..	☐	☐	☐	☐	☐	☐	☐
Asthma ……………..	☐	☐	☐	☐	☐	☐	☐

Physical Activities ____________________________________

Diet/Nutrition_____________________________________

_______________________________________ ________________

Patient Signature **Date**