Kara Romanko, DAOM, L.Ac.,

Health History

Patient's Name____ Today's Date____________________________

Age_______ DOB________

What is the reason for your visits today?____

Symptoms

Check any symptoms you currently have or have had in the past year

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary
- Blood in Urine
- Frequent Urination
- Lack of bladder control
- Painful urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion/Reflux
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐Chest Pain
- High Blood Pressure
- Irregular Heart beat
- Low Blood Pressure
- Poor Circulation
- Rapid heart beat
- Swelling of ankles
- Varicose Veins

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

Skin
- Bruise Easily
- Hives
- Itching
- Change in Moles
- Rash
- Scars
- Sores that won't heal

Men Only
- ☐ Breast Lump
- ☐ Erectile dysfunction
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on Penis
- ☐ Other

Gynecology
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of Last menstrual period________

Date of Last Pap Smear____________

Have you had a mammogram? Y N Are you pregnant? Y N Number of children_______

Menopause __________

Conditions

Past Present		Past Present		Past Present		Past Present	
	AIDS		Chemical Dependency		High Cholesterol		Prostate Problem
	Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care
	Anemia		Diabetes		Kidney Disease		Rheumatic Fever
	Anorexia		Emphysema		Liver Disease		Scarlet Fever
	Appendicitis		Epilepsy		Measles		Stroke
	Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Attempts
	Bleeding Disorders		Gonorrhea		Mononucleosis		Tonsillitis
	Breast Lump		Gout		Multiple Sclerosis		Tuberculosis
	Bronchitis		Heart Disease		Mumps		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infections
	Cataracts		Herpes		Polio		Venereal Disease

Medications
List any medications you are currently taking

____

____

____

Pharmacy Name__________________Phone___________

Allergies

____

____

____

____

Family History

Relation	Age	State of Health	Age at Death	Cause of Death	✓	Check if your blood relatives have had any of the following: Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brother(s)						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease	
Sister(s)						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Tobacco Y N #____day

Caffeine Y N # ____day

Alcohol Y N # _____day/week/month (circle one)

Other Drugs Y N specify ____________

Illnesses

Illness	Date	Outcome

Lifestyle/Occupational

Stress Y N

Heavy Lifting Y N

Hazardous Substances Y N

Other Y N

I certify that the above information is correct to the best of my knowledge. I will not hold Kara Romanko, L.Ac. or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______________________________

Signature Date