❀ Annapolis Acupuncture ❀

PATIENT SURVEY

Name: _____ **Date:** _____/ _____/ _____

Please Check :

GENERAL

Hepatitis _____
HIV_____
Cancer_____
Diabetes_____
Medication_____
Street Drugs_____
Smoking_____
Drinking_____
Pregnant_____

SKIN & HAIR

Rashes _____
Itching_____
Dandruff _____
Ulceration_____
Eczema_____
Loss of Hair _____
Hives_____
Pimples_____
Recent Moles_____

HEAD, EARS, EYES, NOSE THROAT

Headaches_____
Dizziness_____
Concussion_____
Migraine_____

Eye Pain_____
Blurry Vision _____
Night Blindness _____
Color Blindness _____
Cataract _____
Ringing in Ears _____
Earaches _____
Poor Hearing _____
Dental Problems _____
Grinding Teeth _____
Facial Pain_____
Nosebleeds_____
Jaw Clicks _____

CARDIOVASCULAR

High Blood Pressure_____
Low Blood Pressure_____
Irregular Heart Beat_____
Cold Hands/Feet _____
Chest Pain _____
Palpitations_____

RESPIRATORY

Cough_____
Coughing Blood _____
Asthma_____
Bronchitis_____
Pneumonia_____
Pain w/Breathing _____

Difficulty Breathing ____
Sputum_____

GASTROINTESTINAL

Nausea_____
Vomiting _____
Belching _____
Diarrhea_____
Constipation _____
Excessive Gas _____
Blood in Stool _____
Mucus in Stool _____
Indigestion _____
Bad Breath _____
Abdominal Pain _____
Hemorrhoids _____
Chronic Laxative Use____

UROGENITAL

Pain on Urination _____
Urgency to Urinate _____
Blood in Urine _____
Unable to Hold Urine ___
Decrease in Flow _____
Kidney Stones _____
Sores on Genitals_____
Impotence_____