PERSONAL HISTORY FORM

For Michael Rossoff, L.Ac.

NAME | DATE | MARITAL STATUS

ADDRESS | CITY | STATE | ZIP

PRIMARY PHONE | EMAIL

PLACE OF BIRTH | DATE OF BIRTH | AGE

PRIMARY MEDICAL DOCTOR | HEIGHT | WEIGHT

OCCUPATION *(if retired, previous career)* | REFERRED BY

MAIN COMPLAINTS OR SERIOUS DISEASES

PRIORITIZE YOUR MOST SIGNIFICANT CONCERNS IN CHRONOLOGICAL HISTORY

CONCERNS	ONSET	FREQUENCY	SEVERITY
1.			
2.			
3.			
4.			

EXPLANATION OF CONCERNS *(Please be brief)*

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MEDICAL HISTORY *(Give your age when occurred)*

BLOOD TYPE: _____ *Rh-* ☐ Y ☐ N

SIGNIFICANT PAST DISEASES *(Give your age)*

DISEASE	AGE
☐ HBP	
☐ Heart Attack	
☐ Asthma	
☐ COPD	

HOSPITALIZATIONS / SURGERIES *(Give your age)*

CONDITION	AGE	CONDITION	AGE
☐ Tonsils		☐ Breast Implants	
☐ Colonoscopy		☐ Vasectomy	
☐ Gum		☐ Mastectomy	
☐ Dental Implants		☐ Hysterectomy	
☐ Hernia		☐ Partial	
☐ Hemorrhoids		☐ Complete	
☐ Gall Bladder		☐ Medical Devices	

OTHER HOSPITALIZATIONS / SURGERIES *(Give your age)*

CONDITION	AGE

INJURIES / ACCIDENTS *(Give your age)*

INCIDENT	AGE

MEDICATIONS

PAST PRESCRIPTION DRUGS

CURRENT PRESCRIPTION DRUGS

SUPPLEMENTS

DO YOU TAKE

☐ Hormones ☐ Antidepressants

HAVE YOU HAD VACCINES

☐ COVID ☐ Flu ☐ Pneumonia

FAMILY HISTORY *(Only significant medical history)*

FATHER _____ MOTHER _____

SIBLINGS (1) _____ SIBLINGS (3) _____

SIBLINGS (2) _____ SPOUSE _____

BIRTH ORDER You are the _____ of _____ children YOUR CHILDREN _____ # of Boys _____ # of Girls

EATING HABITS *(Check foods you have eaten in the past two weeks)*

Cooking with: ☐ Gas ☐ Electric ☐ Microwave

☐ Whole grains	☐ Dairy products	☐ Rice syrup	☐ Beans, tofu or tempah
☐ Fresh vegetables	☐ Dairy milk	☐ Honey	☐ Fish
☐ Salads	☐ Dairy cheese	☐ Chocolate	☐ Poultry
☐ Seeds and nuts	☐ Mock dairy products	☐ Chips	☐ Eggs
☐ Pasta	☐ Canned foods	☐ Crackers	☐ Pork or lamb
☐ Bread	☐ Frozen food	☐ Artificial sweeteners	☐ Beef

LIQUIDS *(Check liquids you drink a few times a week and how many cups a day)*

☐ Water: cups / day	☐ Caffeine tea: cups / day	☐ Soft drink: cups / day	☐ Beer: cups / day
☐ Herbal tea: cups / day	☐ Coffee: cups / day	☐ Fruit juice: cups / day	☐ Wine/Sake: cups / day

GIVE A TYPICAL MENU *(Use your previous diet if you have changed within three months)*

Breakfast	Lunch	Dinner	Snack and treats

PRESENT CONDITION *(Check all that apply)*

SLEEP ☐ Insomnia ☐ Nightmares ☐ Awaken at night @ a.m.

APPETITE Are you more? ☐ Hot ☐ Cold

DIGESTION ☐ Indigestion ☐ Belching ☐ Bloating ☐ Gas ☐ Cramp

BOWELS Frequency: x/24 hrs ☐ Constipation ☐ Diarrhea ☐ Bleeding

URINATION Frequency: x/24 hrs ☐ Pain ☐ Burning

DRUGS ☐ Marijuana, etc. ☐ Past ☐ Present What kind? How often?

SMOKING ☐ Past Age started Age stopped ☐ Present Frequency: x per day

SEXUAL VITALITY PHYSICAL ACTIVITY

WOMEN ONLY BELOW

MENSTRUATION Age began Cycle (days between periods) Duration ☐ Vaginal discharge

☐ Clots ☐ Cramps ☐ Before flow ☐ After flow Last period began on

☐ Hot flashes Last PAP test date Last Mammogram date

BIRTH CONTROL What age? ☐ IUD ☐ Pill ☐ Condom

PREGNANCIES # of births # of miscarriages # of abortions ☐ Did you nurse How many months