PERSONAL HISTORY FORM

For Michael Rossoff, L.Ac.

NAME _____ DATE _____

ADDRESS _____ AGE _____ MARITAL STATUS _____

CITY _____ STATE _____ ZIP _____ DATE OF BIRTH _____

PHONES [Home] ( ) _____ [Cell] ( ) _____ PLACE OF BIRTH _____

OCCUPATION (If retired, previous work) _____ REFERRED BY _____

PRIMARY MEDICAL DOCTOR _____ E-MAIL _____

MAIN COMPLAINTS OR SERIOUS DISEASES *(Please give significant, chronological history.)*

MEDICAL HISTORY *(Give your age when occurred)*

BLOOD TYPE: _____ *[Rh-* **Y/N** *]*

SIGNIFICANT PAST DISEASES

HOSPITALIZATIONS / SURGERIES *(Give your age)*

❑ Tonsils ____ ❑ Cosmetic ____ ❑ Gum ____ ❑ Hernia ____

❑ Hemorrhoids ____ ❑ Vasectomy ____ ❑ Breast Implants____

❑ Hysterectomy ____ (*Partial* or *Complete*) ❑ Gall Bladder ____

OTHERS:

INJURIES / ACCIDENTS *(Give your age)*

MEDICATIONS *(Include prescription drugs, vitamins, supplements, laxatives, herbs, antidepressants, and hormones)*

PAST

CURRENT

PICTURE **Please draw a composite picture containing all of the following objects —**
● House ● Tree ● Mountain ● Lake ● Snake ● Dragon ● Sun. ***You don't have to be an artist!***

PRESENT CONDITION *[Wherever there is a* **Y/N**, *circle the correct response.]*

SLEEP _____ **Insomnia Y/N Nightmares Y/N Awaken at Night Y/N @** **a.m.**

WEIGHT _____ ***lbs.*** **APPETITE** _____

URINATION Frequency: ***x/24 hrs.*** **Pain: Y/N Burning: Y/N PERSPIRATION** _____

DIGESTION Indigestion: Y/N Belching: Y/N Bloating: Y/N Gas: Y/N Cramps: Y/N Other: _____

BOWELS Frequency: ***x/day*** **Constipation: Y/N Diarrhea: Y/N Bleeding: Y/N** _____

WOMEN ONLY

MENSTRUATION Age Began: Cycle (days between periods): days Duration: ***days*** **Vaginal Discharges: Y/N**

Clots: Y/N Cramps: Y/N Before *or* After flow? (Circle) Last Period Began On: Age at Menopause: Hot Flashes: Y/N

BIRTH CONTROL Which? At what ages? Year of —last Pap Test: —last Mammogram:

PREGNANCIES # Births: # Miscarriages: # Abortions: Did you nurse? Y/N For months *or* years (circle)

DRUGS (Marijuana, cocaine, etc.) Y/N If yes, when? _____ **SMOKING Y/N If yes, x/day**

SEXUAL VITALITY _____ **SMOKING IN PAST Total years: Year Stopped:**

PHYSICAL ACTIVITY (Exercise, sports) _____

EATING HABITS *Give a typical menu. Use your previous diet if you have changed your way of eating within the past 6 months.*

Do you cook with a gas stove? Y/N With an electric stove? Y/N With a microwave? Y/N

BREAKFAST

DINNER

SNACKS and TREATS

LUNCH

LIQUID INTAKE (give cups/day)

FAMILY HISTORY *(Only Significant Medical History)*

BIRTH ORDER: You are the _____ of _____ children.

FATHER _____

MOTHER _____

SIBLINGS _____

SPOUSE _____

YOUR CHILDREN # Boys= # Girls= _____