Oriental Medicinal Arts
Acupuncture and Herbal Medicine
(617) 291-1423
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www.orientalmedicinalarts.com

ORIENTAL MEDICAL QUESTIONNAIRE:

• Check or circle if you have, or have had, any symptoms in the following areas to a significant degree.

General:

- ☐ Bleed or Bruise Easily
- ☐ Chills
- ☐ Food Cravings ( )
- ☐ Change in Appetite (Low • High)
- ☐ Afternoon Flushes
- ☐ Alternating Chills and Fever
- ☐ Fevers (High Grade • Low Grade)
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Cold Body Temperature Sensation
- ☐ Difficulty Keeping Eyes Open in the Day Time
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night Sweats
- ☐ Strong Thirst (Hot • Cold)
- ☐ Sweat Easily
- ☐ Forgetfulness
- ☐ Sensation of Heaviness
- ☐ Hot Body Temperature Sensation
- ☐ Strong Thirst
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Swollen Joints
- ☐ Sudden Energy Drop
- ☐ Easily Catch Cold
- ☐ Nightmares
- ☐ Mental Confusion
- ☐ Restless Sleep
- ☐ Walking During the Night
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Bloating of Stomach After Meals
- ☐ Slow Digestion
- ☐ Strong Appetite
- ☐

• Do you prefer cold weather or hot weather?

• What water temperature do you prefer? Please circle one: Hot Cold Ice Room Temperature

• What is your stress level? (10 is the most stressful, please circle one) 1 2 3 4 5 6 7 8 9 10

Skin and Hair:

- ☐ Atopic Dermatitis
- ☐ Dandruff
- ☐ Eczema
- ☐ Hives
- ☐ Lumps
- ☐ Lipoma
- ☐ Dry Hair
- ☐ Rosacea
- ☐ Itching
- ☐ Loss of Hair
- ☐ Acne
- ☐ Psoriasis
- ☐ Skin Tags
- ☐ Cysts
- ☐ Premature Gray Hair
- ☐ Nail Fungus
- ☐ Growths
- ☐ Spider Veins
- ☐ Dry Scalp
- ☐ Boils
- ☐ Ulcerations
- ☐ Alopecia
- ☐ Greasy Hair
- ☐ Rashes

• Do you have any new recent moles or growths of the skin?

• Do you have any other hair or skin problems?

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Head, Face, Eyes, Ears, Nose, Mouth and Throat:

- ☐ Astigmatism
- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Color Blindness
- ☐ Dizziness
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Grinding Teeth
- ☐ Tremor of Head
- ☐ Swollen Nose
- ☐ Nose Polyps
- ☐ Dry or Cracked Lips
- ☐ Drooping Lips or Deviation
- ☐ Mouth Ulcers
- ☐ Dry Eyes
- ☐ Scratchy Eyes
- ☐ Teary or Watery Eyes
- ☐ Sinus Drainage
- ☐ Sores on Tongue
- ☐ Bloodshot on Eyes
- ☐ Difficulty Swallowing
- ☐ Stuffy Nose
- ☐ Glasses
- ☐ Hyperopia
- ☐ Jaw Clicks
- ☐ Migraines
- ☐ Myopia
- ☐ Night Blindness
- ☐ Nose Bleed
- ☐ Poor Hearing
- ☐ Edema of the Face
- ☐ Double Vision
- ☐ Cold Sores
- ☐ Swollen Gums & Pain
- ☐ Canker Sores
- ☐ Toothache
- ☐ Swollen Sensation of the Throat
- ☐ Photophobia
- ☐ Cavities
- ☐ Strange Taste in the Mouth
- ☐ Loose Teeth
- ☐ Dry Mouth
- ☐ Easily Loss of Voice
- ☐ Headaches
- ☐ Ringing in Ears (Loud • Soft)
- ☐ Spots in front of Eyes
- ☐ Sinus Problems
- ☐ Sores on Tongue
- ☐ Frequent Sore Throat
- ☐ Unconsciousness
- ☐ Sores on Lips
- ☐ Deviation of the Eyes and Mouth
- ☐ Swelling of the Face or Cheeks
- ☐ Sores on the Ear
- ☐ Earache
- ☐ Swollen Neck Glands
- ☐ Post Nasal Drips
- ☐ Earache
- ☐ Ear Infections
- ☐ Loss of Smell
- ☐
- ☐

• How often do you have headaches?

• Do you have any other head, face, eyes, ears, nose, mouth and throat problems?

Cardiovascular:

- ☐ Blood Clots
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Difficulty in Breathing
- ☐ Rheumatic Fever
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Feeling Oppression of Chest
- ☐ Phlebitis
- ☐ Angina
- ☐ Heart Murmur

• Do you have any other heart or blood vessel problems?

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Respiratory:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Cough (Chronic • Acute)
- ☐ Difficulty in Inhaling
- ☐ Difficulty in Exhaling
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Pain with a Deep Breath

• Do you have difficulty laying down?

• Do you have any production of phlegm and what is the color?

• Do you have any other lung problems?

Gastrointestinal:

- ☐ Abdominal Pain and Cramps
- ☐ Bad Breath
- ☐ Belching
- ☐ Blood in Stools
- ☐ Black Stools
- ☐ Constipation
- ☐ Colitis
- ☐ Chronic Laxative Use
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Heartburn
- ☐ Nausea
- ☐ IBS
- ☐ Poor Appetite
- ☐ Rectal Pain
- ☐ Vomiting
- ☐ Mucus in Stools
- ☐ Strong Odor (Stools)
- ☐ Crohn's
- ☐ Other

• Do you feel complete with Bowel Movement?

• Do you have any painful Bowel Movement?

• How frequent are your Bowel Movements?

• Consistency of Bowel Movement: Please circle that all apply: Well-formed Hard Loose Alternates Undigested Food

Genito-Urinary:

- ☐ Blood in Urine
- ☐ Decrease in Urine Flow
- ☐ Kidney Stones
- ☐ Pain or Burning w/ Urination
- ☐ UTI
- ☐ Pain at Genitals
- ☐ Urgency to Urine
- ☐ Unable to Hold Urine
- ☐ Retention
- ☐ KD Infection
- ☐ Bed-wetting
- ☐ Dribbling
- ☐ Scanty Urine
- ☐ Profuse Urine
- ☐

• What is the color of urine ? Please circle that all apply: White Yellow Clear Cloudy Red

• How many times do you urinate per day?

• How many times do you wake up for urination?

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Neurological:

- ☐ Poor Coordination
- ☐ Parkinson's Disease
- ☐ Concussion
- ☐ Loss of Balance
- ☐ Area of Numbness
- ☐ Seizures
- ☐ Tremors
- ☐ Dizziness
- ☐ Other

Musculoskeletal:

- ☐ Back Pain (Low • Middle • Upper)
- ☐ Foot/Ankle Pain
- ☐ Hands/ Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Rotary Cuff
- ☐ Sciatica (Nerve)
- ☐ Fibromialgia
- ☐ Tingling Sensation
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Sprains/ Strains
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Muscle Twitching
- ☐ Easily Broken Bones
- ☐ Soreness in Muscle
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Muscle Cramps
- ☐ Hernia
- ☐ Muscle Spasms
- ☐ Other
- ☐
- ☐

Psychological:

- ☐ ADD/ADHD
- ☐ Anxiety/Worry
- ☐ Depression
- ☐ Easily Angered
- ☐ Guilt
- ☐ Fearful
- ☐ Frustration
- ☐ Panic Attacks
- ☐ PTSD
- ☐ Sadness/ Grief
- ☐ Phobia
- ☐ Obsessive Tendencies
- ☐ Joyful
- ☐ Happiness
- ☐ Nervousness

• Do you or have you ever had a therapist?

• If Yes, are you currently seeing a therapist on a regular basis?

• Have you ever considered suicide?

• Have you ever attempted suicide?

• Do you have any other psychological problems?

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Female Reproductive: (Women Only)

- ☐ Irregular Period
- ☐ Pregnancies #: _____
- ☐ Abortions #: _____
- ☐ C-Section #: _____
- ☐ Miscarriage #: _____
- ☐ Live Births #: _____
- ☐ Premature Births #: _____
- ☐ Age of first Menses #: _____
- ☐ Time between Menses #:_____
- ☐ Duration of Menses #: _____
- ☐ Menopause Age: _____
- ☐ Hysterectomy
- ☐ Anemia ( )
- ☐ Lower Back Pain Associated with Periods
- ☐ PMS
- ☐ Nausea During Periods
- ☐ Infertility
- ☐ Breast Lumps
- ☐ Yeast Infection
- ☐ H/A Associated with Periods
- ☐ Endomitoriosis
- ☐ Vomiting During Periods
- ☐ Uterine Fibroids
- ☐ Uterine Polyps
- ☐ Fibrocystic Breast Disease
- ☐ Ovarian Cysts
- ☐ Ovulation Pain
- ☐ Food Craving Associated with Periods
- ☐ Warts on Genitals
- ☐ Odor of Vaginal Discharge
- ☐ Painful Periods
- ☐ Soreness of Genitals
- ☐ Unusual Vaginal Discharge
- ☐ STD's
- ☐ Cramps Associated with Periods
- ☐ Edema Associated with Periods
- ☐ Pelvic Inflammation Disease
- ☐ Polysystic Ovarian Disease
- ☐ Vaginal Soreness
- ☐ Vaginal Dryness
- ☐ Emotional Change Associated with Periods

• Are you pregnant? If so, how many months?

• Is it possible you are pregnant?

• Do you practice birth control pills? If so, what types of pills? How long are you taking?

• What is your color of vaginal discharge? Please circle one: Clear _ White _ Yellow _ Pink _ Red

• When was the last PAP Smear? Date: _____ How was the result?

• Abnormal PAP Smear in the past? Date _____ Result: _____

• Have you ever had cervical biopsy or operation?

• Do you experience any uterine bleeding outside of the menses or spotting between periods?

• If Yes, how much and how often?

• When was the last Mammogram Date: _____ Result: _____

• Have you ever had breast biopsy due to abnormality and how was the result?

• Do you experience any Blood Pressure drops during periods?

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If you are experience clots in your menstrual blood, please circle the size and amount:

Dime Size _ Quarter Size _ More than Quarter Size / Few _ Moderate _ A lot

• Please fill in the menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Amount of Flow: (Heavy, Medium, Light, Spotting)							
Color: (Dark Red, Bright Red, Pale Red, Purplish Red, Brownish Red)							
Pain / Cramps: (Sharp, Stabbing, Dull, Moderate, Other)							
Clots / Fibrous (Purplish, Dark Red, Black, Other)							
Vomiting (Severe, Moderate, Light)							
Nausea (Severe, Moderate, Light)							
Other Symptoms							

• Do you have any cramps before periods?

• Do you have any headches before or after periods?

• Do you have any other female reprocuctive system problems?