Mill-e-Moto
12005 SW 70th Ave
Tigard, OR 97223
p: (503) 372-6463 f: (503) 214-8470

Patient Health History

Welcome to Mill-e-Moto Center for Traditional East Asian Medicine, it is our goal to help each patient improve their quality of life and to achieve optimum health. In order to serve you best we encourage you to fill out this survey in as much detail as possible. All symptoms that you experience are relevant and important to us as TEAM practitioners. All information will be held in strict confidence. **Thank you.**

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address: _____ City/State: _____ Zip:_____

Telephone#: (H)_____ (C)_____ E-Mail:_____

Circle your choice: *Yes I do / No I do not* agree to receive occasional emails in reagrd to appointments, check-ins and clinic info.

Emergency Contact (Name /Telephone #):_____

Date of Birth: _____/_____/_____ Age: _____ Marital status: S M D W

When and where did you last receive health care? _____

For what reason? _____

Has your case been referred to an attorney? Y N

Please identify the health concerns that have brought you to Mill-e-Moto in order of importance:

Condition	**Past Treatment**
1) _____	_____
How does this condition affect you? _____	
2) _____	_____
How does this condition affect you? _____	
3) _____	_____
How does this condition affect you? _____	
4) _____	_____
How does this condition affect you? _____	

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

Please list medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

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Do you have any infectious diseases? Y N If yes, please identify: _____

Hospitalizations and Surgeries:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

X-Rays/CAT Scans/MRI's/Special Studies:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: ***Check those applicable***:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Below, please CHECK any that you have now, and <u>UNDERLINE</u> any that you have experienced in the <u>past</u>

<u>Emotional</u>
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Mental Tension

<u>Energy and Immunity</u>
- ☐ Fatigue
- ☐ Slow Wound Healing
- ☐ Chronic Infections
- ☐ Chronic Fatigue Syndrome

<u>Head, Eye, Ear, Nose, & Throat</u>
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Tearing/Dryness
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ TMJ/Jaw Problems
- ☐ Hay Fever

Respiratory
- ☐ Pneumonia
- ☐ Frequent Common Cold
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Other Respiratory Problems

<u>Cardiovascular</u>
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations/Fluttering
- ☐ Stroke
- ☐ Heart Murmurs
- ☐ Rheumatic Fever

<u>Gastrointestinal</u>
- ☐ Ulcers
- ☐ Changes in Appetite

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- ☐ Nausea/Vomiting
- ☐ Stomach Pain
- ☐ Frequent Gas
- ☐ Heartburn
- ☐ Frequent Belching
- ☐ Gall Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis

Genito-Urinary Tract

- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Kidney Stones

Female Reproductive

- ☐ Irregular Cycles
- ☐ Breast Lumps/Tenderness
- ☐ Nipple Discharge
- ☐ Heavy Flow
- ☐ Vaginal Discharge
- ☐ Premenstrual Problems
- ☐ Bleeding Between Cycles
- ☐ Menopausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Painful Periods

Male Reproductive

- ☐ Sexual Difficulties
- ☐ Prostrate Problems
- ☐ Testicular Pain/Swelling

Musculoskeletal

- ☐ Neck/Shoulder Pain
- ☐ Muscle Spasms/Cramp
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Joint Pains

Neurological

- ☐ Vertigo/Dizziness
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy

Endocrine

- ☐ Thyroid Disorder
- ☐ Hypoglycemia
- ☐ Diabetes Mellitus
- ☐ Night Sweats
- ☐ Feeling Hot or Cold

Other

- ☐ Anemia
- ☐ Cancer
- ☐ Rashes
- ☐ Eczema/Hives
- ☐ Cold Hands/Feet

Menstrual/Birthing History:

Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you?_____

Age of First Menses: _____ # of Days of Menses: _____ Length of Cycle: _____
Birth Control Type: _____ # of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____
# of Live Births: _____
Is there anything else we should know? _____

_____

Lifestyle:

Do you feel you have a healthy diet? Y N

Exercise routine: _____

On average, how many hours per night do you sleep? _____ Do you wake rested? Y N

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not?

_____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N Explain: _____

_____

_____

How many glasses of water do you drink per day? _____

Interests and hobbies: _____

Patient Initials_____ Patient DOB_____

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How did you hear about us? _____