Enhong Yu, L.Ac.
Lumina AcuClinic
Tel: 910-256-3939
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info@luminaacuclinic.com

New Patient Questionnaire

Name: _____ Date: _____/_____/_____
(First) (Middle) (Last)

Date of Birth: _____/_____/_____ Gender: □ M □ F Marital Status: □ Single □ Married □ Widowed □ Divorced

Address: _____

City _____ _____State _____ Zip _____

Phone: Day ( ) _____ Eve ( ) _____ Cell ( ) _____

Email: _____

How did you hear about us? _____

Would you like to receive our email newsletter? _____

In Case of Emergency, Contact (Name/Relationship/Phone Number): _____

Primary Physician's Name: _____

Other Physicians you see regularly and for what conditions: _____

_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

When and where did you last receive health care? _____

For what reason? _____

Please identify the health concerns that have brought you to the Lumina AcuClinic in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

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How does this condition affect you? _____

c. _____ _____

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

_____

_____

Do you have any reason to believe you may be pregnant? □ Yes □ No If so, how far along are you?_____

Do you have any infectious diseases? □ Yes □ No If yes, please identify: _____

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

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

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

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: _____

Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

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Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia | Frequent Common Colds | Difficulty Breathing | Emphysema

Persistent Cough | Pleurisy | Asthma | Tuberculosis

Shortness of Breath | Other Respiratory Problems: _____

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease | Chest Pain | Swelling of Ankles | High Blood Pressure

Palpitations/Fluttering | Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers | Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Passing Gas | Heartburn

Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Heavy Flow

Kidney Stones | Impaired Urination | Blood in Urine | Frequent Urination at Night

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles | Breast Lumps/Tenderness | Nipple Discharge | Heavy Flow

Vaginal Discharge | Premenstrual Problems | Clotting | Bleeding Between Cycles

Menopausal Symptoms | Difficulty Conceiving | Painful Periods

Menstrual/Birthing History:

1. Age of First Menses: _____
2. # Of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # Of Pregnancies: _____
6. # Of Miscarriages: _____
7. # Of Abortions: _____
8. # Of Live Births: _____
9. Date of last period:_____

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties | Prostrate Problems | Testicular Pain/Swelling | Penile Discharge

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Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

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

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

Lifestyle:

Do you typically eat at least three meals per day? Yes No If not, how many? _____

Exercise routine: _____

How many hours per night do you sleep? _____ Do you wake rested? Yes No

Occupation: _____ Hours/Week: _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Yes No Explain: _____

_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

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