



Lance David Isakov, L.Ac.
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Health History

Please help us provide you with a complete evaluation by taking the time (about 15 minutes) to fill out this questionnaire carefully. All answers are completely confidential.

Please print clearly in ink.

Name: _____ Sex: M / F Date: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth _____ Place of birth _____ Age _____ Height _____ Weight _____

Telephone: Home () _____ Work () _____ Cell () _____

_____ Single _____ Married _____ Divorced _____ Widowed _____ Living with

Education: _____ Occupation: _____

Referred by: _____

Reason for visit today: _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your : Sleep _____ Work _____ Other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	Self	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Age of death						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Muscular-skeletal disorder						
Blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

MEDICINES:

Prescription drugs you are currently taking:	For what condition?
_____	_____
_____	_____
_____	_____

Over-the-counter medication you are currently taking:	For what condition?
_____	_____
_____	_____
_____	_____

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

Year	Operation/illness

Date of last physical examination: _____

Name & address of physician: _____

Phone number of physician: _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes no when: _____ Length of cycle _____

Color of menstrual blood: pale bright red dark red brown other _____

Texture of menstrual blood: thick thin watery normal

Pain: yes no when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

Please put a "C" if the condition is current or a "P" if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain

- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath

- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder
- Musculoskeletal Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital
- Other



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Informed Consent Form

I hereby voluntarily consent to be treated by Lance Isakov, L.Ac., with oriental medical procedures, which may include acupuncture, moxibustion, acupressure, massage, herbal medicine, or nutrition and lifestyle counseling. Lance Isakov is a licensed acupuncturist in the Commonwealth of Pennsylvania.

I understand that acupuncture is performed by the insertion of sterile, single use needles through the skin, or by the application of heat to the skin, or by both, at certain points near the surface of the body in an attempt to treat body dysfunctions or diseases and to normalize the body;s physiological functions.

I understand that all my patient records as well as information I share with my acupuncturist will be kept confidential. No records or information will be released without my written consent. I acknowledge that I have received the HIPPA Notice of Privacy Practices. This form is located on at www.LanceIsakov.com

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears that i should consult my personal physician or any other licensed physician.

I understand that i should inform my acupuncturist prior to being treated if I believe I might be pregnant.

I understand that no guarantees concerning acupuncture's use and effects are given to me, and that i am free to stop acupuncture treatment at any time.

None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate.

I understand I will be charged the full fee for appointments cancelled with less than 24 hours notice.

I have carefully read and understand all the foregoing and so am fully aware of what i am signing. I have felt free to ask any questions.

Print name of patient

Date

Signed by patient or guardian

Date