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