Patient Information:
Name_____
Date of Birth: _____/_____/_____
Email:_____
Contact Phone: _____
Address:_____

Michael Kalsman M.D.
Medical Acupuncture

Medical History

Primary complaint:_____

Current Medical Problems that you are treated for:

_____
_____
_____
_____
_____
_____
_____
_____

Current Medications (please include herbal, OTC meds):

_____
_____
_____
_____
_____

Allergies (food, environmental and medications):

_____
_____

Past major illness, accidents, surgeries, hospitalizations, traumas:

Age/Year	Event Detail
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past major illness, accidents, surgeries, hospitalizations, traumas (Continued):

Age/Year	Event Detail
_____	_____
_____	_____
_____	_____
_____	_____

Scars:

Location:_____ Cause:_____Painful : YES/NO

Location:_____ Cause:_____Painful : YES/NO

Location:_____ Cause:_____Painful : YES/NO

Location:_____ Cause:_____Painful : YES/NO

Location:_____ Cause:_____Painful : YES/NO

Habits: (circle appropriate answers)

Have you ever used tobacco? Yes/No Cigarettes Cigars Chew

How much: _____pack/day _____cigars/chew/day

How old were you when you started? _____ when you quit?_____

Do you currently drink alcohol? Yes/No Drinks per week:_____

Any history of past alcohol use? Yes/No

Any other substance use (marijuana, other illicit drugs): Yes/No

Do you exercise regularly? Yes/No

How many times a week? 1 2 3 4 5 6 7 more than 7

What is your favorite type of exercise? _____

How do you consider your general diet? Poor Average Good Very Healthy

Family History: Please list any major illnesses including cancer, diabetes, heart disease, neurological disorders, blood disorders , genetic disorders, etc that have occurred in your family.

_____

_____

_____