Lam Clinic of Traditional Chinese Medicine

825 S Broadway • Boulder, Colorado 80305 • 303.444.2357

Welcome to the Lam Clinic of Traditional Chinese Medicine. To help us provide you with the best possible care, please complete this form. This information will remain confidential.

Your Name: Date of Birth: / / Age:

O Male O Female Social Security Number:

Street Address: City: State: Zip:

Phone (day): Phone (evening):
Occupation:

Email:

In case of emergency, contact:
Name: Relationship: Phone:
Street Address: City: State: Zip:

How did you hear about us?

Please describe your reason for today's visit:

Have you ever had this difficulty or a similar one before? If yes, please explain:

Is it getting O better O worse or O staying about the same?

What seems to make it feel better?

What seems to make it feel worse?

Are you being treated elsewhere? O Yes O No
By whom?

What was the diagnosis?

What were the results of treatment?

Are you currently taking prescription medicines, herbs, or supplements? O Yes O No
If so, which ones?

Personal Medical History
Please check appliable boxes if you have had any of these medical conditions:

O Addiction (drugs or alcohol)
O AIDS/ARC
O Allergies
O Anemia
O Appendicitis
O Arteriosclerosis
O Asthma
O Bleeding Tendency
O Blood Pressure (low)
O Blood Pressure (high)
O Cancer
O Chicken Pox
O Diabetes
O Digestive Disorder
O Emotional Difficulties
O Emphysema
O Epilepsy
O Fatigue
O Gout
O Headaches
O Heart Disease
O Hepatitis
O Herpes
O HIV positive
O Hypoglycemia
O Injuries
O Insomnia
O Intestinal Parasites
O Measles
O Multiple Sclerosis
O Mumps
O Pacemaker
O Polio
O Rheumatic Fever
O Scarlet Fever
O Sexually Transmitted Disease
O Stroke
O Surgery (list) ________________
____
____

O Thyroid Disorders
O Trauma (falls, accidents)
O Tuberculosis
O Ulcers
O Other: _______________________
____

Family Medical History
Please check appliable boxes if anyone in your family has these conditions:

O Alcoholism
O Allergies (list)
____
____
O Arteriosclerosis
O Asthma
O Cancer
O Diabetes
O Heart Disease
O High Blood Pressure
O Seizures
O Stroke

Please describe what you eat in a typical day:
Breakfast:

Lunch:

Dinner:

Snacks:

Medications:

Coffee:
Cigarettes:
Marijuana:
Recreational drugs:

Symptom Review
Please put one check by a symptom you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

Heart and Chest
o Headaches o Palpitations o Nervousness
o Dizziness o High blood pressure o Tremors
o Memory loss o Tightness in chest
o Convulsions o Other o Low blood pressure

Neurological
o Numbness or tingling o Other o Nerve pain
o Difficulty lying flat o Lack of coordination

Eyes
o Blurred vision o Eyelid problem o Other
o Floaters o Pain

Circulation
o Pain o Bruise easily o Bleed easily
o Cold limbs, hands, or feet o Hot palms
o Overall feeling of warmth
o Overall feeling of cold o Other

Sleep
o Insomnia o Drowsiness
o Excessive dreaming o Other

Ears
o Hearing difficulty o Other
o Earaches o Ringing (circle Low/High)

Nose
o Sinus trouble o Congestion

Mouth
o Gum problems o Dental problems
o Unusual tastes o Tongue problems

Urinary
o Frequent o Nighttime o Cloudy
o Difficult o Painful o Bleedingo Other
o Discharge

Throat
o Sore throat o Other
o Hoarseness
o Difficulty swallowing

Skin
o Rashes o Dryness
o Moles or lumps that change
o Lumps that don’t change
o Excessive sweating o Night sweating
o Seldom sweat o Other

Respiration
o Difficulty inhaling o Difficulty exhaling
o Cough

Digestion
o Excessive appetite o Normal
o Low appetite o Other
o Always thirsty o Jaw problems
o Never thirsty o Nausea
o Stomach or abdominal pain

Bowel Movement
o Diarrhea o Constipation
o Rectal bleeding
o Colon problemso Bleeding
o Pain

Women Only

Are you or might you be pregnant?
o Yes o No o Maybe.
If yes, what month?__________
What method of birth control do you use?
____
Do you have regular PAP tests? o Yes o No.
How often?______________
Are you experiencing unusually low or high sexual desire? Other difficulties?
Age at first menstruation:
Age at menopause:
Date of first day of last menstrual cycle:
Number of days of last menstruation (bleeding):
Usual length of monthly cycle (from first day of bleeding until day before next bleeding):

Are your periods…
o Irregular: o Short o Long o Variable
o Light blood o Thick blood o Watery blood
o Heavy bleeding o Heavy clotting
o Light bleeding o Stop and start again
o Dark blood… o Red o Purple o Brown
o Spotting… o Before o After o Mid-cycle
o **Painful:**
o Before o During o After o Mid-cycle
Relieved by… o Heat o Cold o Pressure

Do you have any pre-menstrual symptoms?
o Painful or swollen breasts o Nausea
o Irritability o Cramps or pain o Crying
o Depression o Other:
o Food cravings:

Vaginal discharge
o Normal o Bad odor o Watery o Itching
o Thick o Dryness o Yellow o Other:
o Clear or white

Gynecological surgeries or problems (please describe)
o Ovaries: o Vagina: o Uterus: o Breasts:
o Fallopian Tubes: o Other:

Pregnancies
Total number:
Complications:
Number of children:
Abortions or miscarriages:
How long ago was your last pregnancy?

Men Only

Do you experience…
o Reduced libido o Urinary frequency
o Excessive libido o Impotence
o Premature ejaculation o Genital discharge
o Seminal emission (spontaneous ejaculation without sexual stimulation)
o Pain associated with genitals
o Other:

Thank you for completing this form. If you need additional space to list health history, please use the space below.