

Metta Oriental Medicine, P.C.

2653 Tarna Drive,
Dallas, TX 75229
972-247-1231

New Patient In-Take Form

Contact Information (Please print)

Date: _____

Name (first & last): _____

Date of Birth: ___/___/___ Age: _____ Occupation: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

In Emergency Notify: Name: _____ Phone: _____

You were referred by: _____

Health Information

Please list your major health complaint(s): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?

When did the problem begin (be specific): _____

If you have seen a medical doctor, what is your diagnosis? _____

What kind of treatments/therapies have you tried? _____

Past Medical History – please note type and dates:

Cancer: _____ Rheumatic Fever: _____

HIV/AIDS: _____ Hepatitis: _____

Thyroid Disease: _____ Heart Disease: _____

Diabetes: _____ Venereal Disease: _____

High Blood Pressure: _____ Other: _____

Asthma: _____

Surgeries (type & dates): _____

Significant Traumas: _____

Significant Dental Work: _____

Allergies (drugs, chemicals, foods, etc.): _____

Stress (occupational, chemical, physical, psychological): _____

Birth History (prolonged labor, forceps, premature, etc.) _____

Family Medical History

- 🍏 Cancer
- 🍏 Diabetes
- 🍏 High Blood Pressure

- 🍏 Heart Disease
- 🍏 Stroke
- 🍏 Seizures

- 🍏 Asthma
 - 🍏 Allergies
 - 🍏 Other
-

Medications

What medications and/or supplements are you currently taking? _____

Habits

Do you have a regular exercise program? Please describe: _____

Are you or have you been on a restricted diet? What kind and why? _____

Please describe your average daily diet (including liquids):

Morning: _____

Afternoon: _____

Evening: _____

Current Health Condition: please circle symptoms which you have experienced in the past 3 months

Energy, Immunity, and Temperature

Fatigue Catch colds easily Sweat easily Cold hands/feet

Energy drops Slow wound healing Night sweats

General weakness Chronic infections Chills

Overall Body Temperature: _____ Overall Energy Level _____

Head, Eye, Ear, Nose, and Throat

Headache/Migraine Eye strain/pain Nasal congestion Hoarseness

Dizziness/Vertigo Ear ringing Teeth grinding Swollen glands

Blurry vision Earaches TMJ/Jaw problems

Floaters Sinus problems Snoring

Photosensitivity Nose bleeds Sore throat

Respiratory

Asthma/Wheezing Cough Allergies

Phlegm Shortness of breath

Cardiovascular

Palpitations High cholesterol Chest pain

High blood pressure Fainting Varicose veins

Gastrointestinal

Low appetite	Bloating	Belching	Constipation
Excessive appetite	Heartburn	Stomach growling	Hemorrhoids
Bad breath	Ulcers	Diarrhea	Abdominal pain
Nausea/Vomiting	Gas	Loose stools	Gallbladder stone

Genito-urinary

Pain/Burning on urination	Waking at night to urinate	Kidney Stones
Urinary urgency	Dribbling urination	Blood in urine
Frequent urination	Profuse urination	Urinary tract infections
Incontinence	Retention of urine	

Neuro-muscular

Seizures	Lack of coordination	Poor memory	Numbness/Tingling
Paralysis	Loss of balance	Poor concentration	Muscle spasms

Sleep

Trouble falling asleep	Tired upon waking	Nightmares
Trouble staying asleep	Excessive dreaming	
What hour do you go to sleep? _____	What hour do you wake up? _____	

Emotions

Mood swings	Anxiety/Panic attacks	Fits of laughter
Sadness	Irritability/Anger	Depression
Nervousness	Mania/Highly elevated mood	Obsessive/Compulsive
Fear	Frequent worrying	

Skin and Hair

Acne	Itching	Rashes	Bruising easily
Dandruff	Dry skin/scalp	Hair loss	Sores

Bowel Movements:

Frequency: _____	Feels complete? <input type="checkbox"/> Yes <input type="checkbox"/> No
Consistency: Well-formed	Hard Loose Alternates
Stools: Undigested food	Blood Mucus

Men Only: Please check all that apply

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Poor sperm motility | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Irregular sperm morphology | |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Premature ejaculation | |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Nocturnal emissions | |
| <input type="checkbox"/> Low sperm count | | |

Women Only:

At what age did you get your first period: _____ First day of last menstrual period: _____

Are you currently using birth control Yes No What type and for how long?

Is there any chance you are pregnant now? Yes No

Are your menstrual cycles spaced regularly? Yes No

Length of cycle: _____ Length of menstrual period: _____

Do you experience any of the following associated with your period each month?

- | | | |
|--|---|--|
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Migraines | <input type="checkbox"/> Heavy bleeding |
| <input type="checkbox"/> Breast tenderness or swelling | <input type="checkbox"/> Changes in bowel movements | <input type="checkbox"/> Scanty bleeding |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Acne | |

Do you experience any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Abnormal vaginal discharge | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Low sex drive | |
| | <input type="checkbox"/> Pain during intercourse | |

Number of pregnancies: _____ Number of abortions: _____

Number of miscarriages: _____ Number of live births: _____

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe: _____

Signature

Date