Questions of Traditional Chinese Medicine

Name _____ Date _____ File # _____ OA# _____

Chief Complaint _____
Onset _____
Duration _____
Doctor's Name _____
Doctors Clinic Name _____
Doctors Diagnosis _____
Previous Treatment _____
Previous Therapies _____
Prescriptions/Medications _____

Tongue
Shape_____
Coating_____
Moisture_____

Pulse
Right_____
Left_____

Chills and Fever
Do you have Chills and Fever? Yes No
If so, when do they occur? _____

TCM Diagnosis
_____

Perspiration
Do you perspire? Yes No
Perspire after heavy or slight exertion? Heavy Slight
Does it have an odor? Yes No
Do you perspire at night? Yes No
Do you perspire spontaneously? Yes No

Doctor Notes:

Appetite and Thirst
How is your appetite? _____
Any Changes Lately? _____
Any abnormal weight loss or gain? _____
How is your Thirst? _____
Do you prefer Hot Drinks or Cold Drinks? _____
Any Food Cravings? _____
Any feeling of fullness after a meal? Yes No
Any Unusual tastes in your mouth? _____

Doctor Notes:

Bodily Waste
Do you get Constipated? Yes No
Do You have diarrhea? Yes No
How many Bowel Movements a day? _____
How many times do you urinate a day? _____
Is it a lot or urine or a little? Normal A lot A Little
What color is the urine? Clear Yellow Dark Cloudy
Any Pain or Difficulty? Yes No
What is the stool Consistency? Dry Moist
Do you feel like you are finished? Yes No

Doctor Notes:

Pain
Does it move? Yes No
If you have headaches. Where? _____
What time of day do you feel the pain? _____

Doctor Notes:

Sleep
Do you sleep well? _____
How many hours per night? _____
Do you have trouble getting to sleep? _____
Do you have Trouble staying asleep? _____
Do you feel tired in the morning? _____
Any reoccurring dreams or nightmares? _____

Doctor Notes:

Menstrual Cycle and Delivery
Any C-Sections? _____
Any Surgeries? _____
Any Procedures? _____
How many Natural Births? _____
When was your last period? _____
Is your period the same time each month? _____
How far apart is your cycle? _____
Is your flow heavy or light? _____
What color is it? _____
Any Clots? _____
Any Vaginal discharge? _____
What is the discharge color and odor? _____

Doctor Notes: