What is your main concern and when did it start?

If you have a pain condition, please mark on the diagram where it hurts with an X:

If you have a pain condition, on average how severe is your pain?

- [ ] 0 No Pain
- [ ] 1 Mild Pain
- [ ] 2 Moderate Pain
- [ ] 3 Severe Pain
- [ ] 4 Unbearable

On average how much fatigue do you feel?

- [ ] 0 No Fatigue
- [ ] 1 Mild Fatigue
- [ ] 2 Moderate Fatigue
- [ ] 3 Severe Fatigue
- [ ] 4 Bedbound

How many hours do you sleep a day?

- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

What is the quality of your sleep?

- [ ] 0 Very Poor
- [ ] 1 Poor
- [ ] 2 Bad
- [ ] 3 Good
- [ ] 4 Restful
- [ ] 5 Very Restful
NEW PATIENT REVIEW FORM
UCLA CENTER FOR EAST–WEST MEDICINE

Please list all of your medical problems.

________________________________________

________________________________________

________________________________________

Please list any medications/herb/vitamins/minerals/supplements you are taking.

________________________________________

________________________________________

________________________________________

What surgical or medical procedures have you had in the past?

________________________________________

________________________________________

________________________________________

Are you pregnant or think you may be pregnant? ☐ No ☐ Yes, ________

How much alcohol do you drink and how often? ________

Do you smoke? ☐ No ☐ Yes If yes, how much and how often? ________

What medical problems do your relatives have?

________________________________________

________________________________________

________________________________________

Do you have any of these symptoms? (check as many as apply).

☐ Fevers  ☐ Frequent colds  ☐ Heat sensitivity  ☐ Dizziness
☐ Chills   ☐ Fungal infections ☐ Cold sensitivity  ☐ Numbness
☐ Blurry vision ☐ Chest pain ☐ Skin Rash ☐ Anxiety
☐ Eye pain  ☐ Palpitations  ☐ Breast pain  ☐ Depression
☐ Hearing loss ☐ Constipation ☐ Muscle soreness  ☐ Work stress
☐ Sore throat ☐ Diarrhea  ☐ Joint pain  ☐ Family stress
☐ Cough    ☐ Urinary frequency ☐ Easy bruising  ☐ Post-traumatic stress
☐ Shortness of breath ☐ Painful urination ☐ Extremity swelling ☐ Weight

Patient or Representative Signature __________________________ Date ________ Time ________

If signed by someone other than the patient, please specify relationship to the patient: __________________