

**Patrick Purdue, Dipl.Ac., A.P., D.O.M.**  
 Acupuncture Physician  
 10010 Seminole Blvd., Seminole, Florida 33772  
 Phone: (727) 319-8819 Fax: (727) 319-8320

Patient History Form			
Patient Name:			
Street:			
City:		State:	ZIP:
D.O.B.	Age:	Height:	Weight:
Occupation:		Work Phone:	Marital Status:
Home Phone:		Cell Phone:	
Email Address:			Email List ___Yes ___No
Emergency Contact (Name, Relationship, Phone Number):			
Primary Care Physician (Name & Phone Number):			
Who Referred You?			

Have you tried natural medicine, homeopathy, acupuncture, Oriental medicine and/or herbal medicine before?

\_\_\_\_\_

Main problem(s) you'd like us to help you with:

\_\_\_\_\_

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

\_\_\_\_\_

Have you been given a diagnosis for these problems?

\_\_\_\_\_

What kinds of treatments have you tried?

\_\_\_\_\_

Have past treatments been successful or helped in any way?

\_\_\_\_\_

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Significant Illnesses (Circle): Cancer / Diabetes / Hepatitis / High Blood Pressure / Heart Disease / Rheumatic Fever / Thyroid Disease / Seizures / Venereal Disease / Other:

Surgeries (List types of surgery and dates):

Allergies (drugs, food, chemicals, etc.):

Family History of any of the following (Circle & Explain)? Diabetes / Cancer / High Blood Pressure / Heart Disease / Stroke / Seizures / Asthma / Allergies / Other:

Prescription or Over-the-Counter drugs taken currently or over the last two months:

Vitamin or mineral supplements currently taking:

Do you have personal stress related to your occupation or personal life?

Do you exercise (if yes, describe type and how often)?

What do you typically eat for breakfast?

What do you typically eat for lunch?

What do you typically eat for dinner?

Do you smoke cigarettes? \_\_\_\_\_ If yes, how many per day? \_\_\_\_\_

How much coffee, tea or soda do you drink weekly? \_\_\_\_\_

How much alcohol do you drink weekly? \_\_\_\_\_

Please describe any drugs used for non-medical purposes \_\_\_\_\_

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**General Health** (Please circle all that apply):

Poor Appetite / Fevers / Sweat Easily / Localized Weakness / Bleed or Bruise Easily /  
Peculiar Tastes or Smells / Strong Thirst (cold or hot drinks) / Sudden Energy Drop  
(What time of day \_\_\_\_\_) / Poor Sleeping / Chills / Tremors / Poor Balance / Weight  
(Rapid Gain or Loss)

**If you suffer aches, pains or other uncomfortable sensations, please circle the  
area(s) involved:**

