



**UCLA Center for East-West Medicine**  
2428 Santa Monica Blvd. Suite 208  
Santa Monica, CA 90404  
Telephone: 310-998-9118  
Fax: 310-829-9318

## **NEW PATIENT REVIEW FORM**

Thank you for choosing the UCLA Center for East-West Medicine Clinic for your health care need. In order to optimize your care, we ask that you fill out this form so that we can match you with the provider best suited to your need. The team of clinicians at the Center for East-West Medicine integrate the best of both modern Western medicine and traditional Chinese medicine to solve health problems and enhance wellness. To learn more about our approaches, you may go to our website: [www.cewm.med.ucla.edu](http://www.cewm.med.ucla.edu).

Please FAX the form to us at **(310) 829-9318**, mail it to the address provided above. Our staff will telephone you to set up an appointment. Due to high volume of patient visits please expect to wait up to 2 weeks for your first appointment.

***To protect patient confidentiality, our staff will be unable to use email to schedule your appointment or answer your medical questions.***

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

UCLA Patient ID Number \_\_\_\_\_

**Check preferred phone number to call:**

Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_

Date Time Phone (if different from above) \_\_\_\_\_

Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Gender \_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed

If you were referred to this Clinic, please provide the following information about your referral physician:

Name \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Your Primary Care Physician (If different from above):

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Your medical insurance (s) \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Is this a Worker's Compensation case? Yes \_\_\_\_ No \_\_\_\_ . Is this a Personal Injury case? Yes \_\_\_\_ No \_\_\_\_

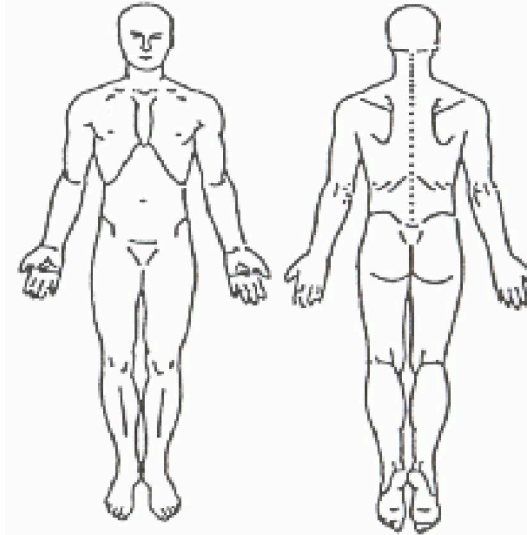
What is your main concern and when did it start?

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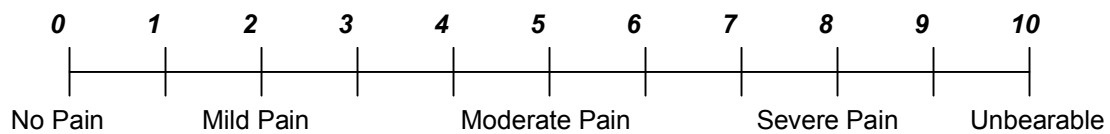
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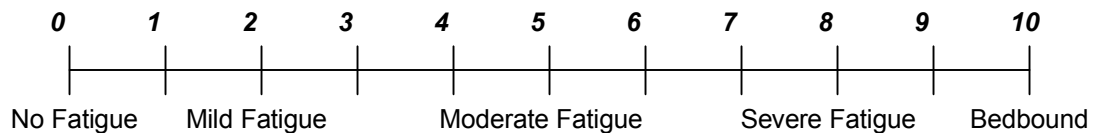
If you have a pain condition, please mark on the diagram where it hurts with an **X**



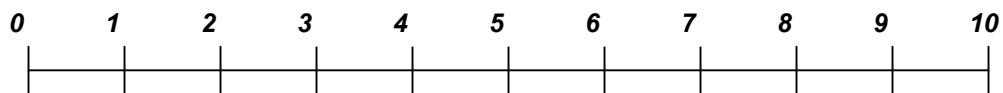
If you have a pain condition, on average how severe is your pain?



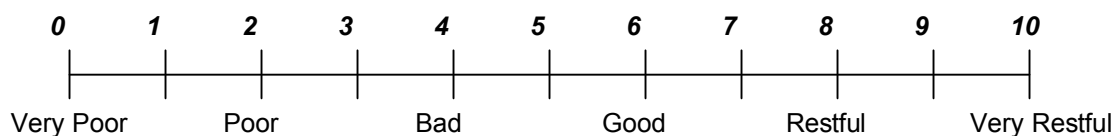
On average how much fatigue do you feel?



On average how many hours do you sleep a day?



What is the quality of your sleep?



Please list all of your medical problems.

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

Do you have any allergies to medications, foods, or environmental exposures?

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

How much alcohol do you drink and how often? \_\_\_\_\_

Do you smoke? \_\_\_\_ If so, how much and how often? \_\_\_\_\_

What medical problems do your relatives have?

Do you have any of these symptoms? Circle 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