HEALTH HISTORY QUESTIONNAIRE

Date _______________

Please help us provide you with a complete evaluation, by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the additional comments section. Thank you.

Name____ Email _______________________________________

Phones: Home _____________________________________

Work _____________________________________

Cell _____________________________________

Address ____ City ___________________ State _______ Zip ___________

Age _______ Date of Birth ________________ Place of Birth ____

Height ______________ Weight ______________

Employer Name ___________________________________ Occupation ____

Family Physician _________________________________ Referred by ____

In Emergency, notify ______________________________ Phone ____

Have you been treated by Acupuncture or Oriental Medicine before? ___ Yes ___ No

What is the main concern you would like us to help you with? ____

____

How long ago did this problem begin (be specific)? ____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?

____

____

Have you been given a diagnosis for this concern? If so, what? ____

____

What kinds of treatment have you tried? ____

____

In order to change this condition, are you willing to make modifications in your lifestyle? ___ Yes ___ No

Comments____

HEALTH HISTORY QUESTIONNAIRE – PAGE 2

Name ____

Your Past Medical History (Please check all that apply, and include dates)

_____ Cancer
_____ Hepatitis
_____ Seizures
_____ Heart Disease
_____ Diabetes
_____ High Blood Pressure
_____ Rheumatic Fever
_____ Thyroid Disease
_____ Venereal Disease
_____ Drug Addiction
_____ Alcoholism
_____ Eating Disorder
_____ Other

Surgeries (Type of surgery and dates) ____

____

Significant Trauma (Auto accidents, falls, etc.) ____

____

Significant Dental Work (Type and dates) ____

Birth History (Prolonged labor, forceps delivery, etc.) ____

List any Known Allergies ____

Family Medical History (Please check all that apply)

_____ Cancer
_____ Seizures
_____ Heart Disease
_____ Stroke
_____ Diabetes
_____ High Blood Pressure
_____ Asthma
_____ Allergies
_____ Kidney Disease
_____ Glaucoma
_____ Tuberculosis
_____ Other

Medicines taken within the last two months (vitamins, drugs, herbs, etc.) ____

____

Occupational Stress (Chemical, physical, psychological, etc.) ____

Do you have a regular exercise program? Yes ____ No ____ Please describe ____

____

Have you ever been on a restricted diet? Yes ____ No ____ What kind? ____

____

Please describe your average daily diet:
Morning ____

Afternoon ____

Evening ____

How many packs of cigarettes do you smoke per day? ____

How much coffee, tea, or cola do you drink per week? ____

How much alcohol do you drink per week? ____

Please describe any use of drugs for non-medical purposes ____

HEALTH HISTORY QUESTIONNAIRE – PAGE 3

Name ____

Please check any of the following symptoms you have had

Within the Last Three Months:

GENERAL

- [ ] Chills
- [ ] Fevers
- [ ] Sweat easily
- [ ] Night sweats
- [ ] Localized weakness
- [ ] Bleed or bruise easily
- [ ] Peculiar tastes or smells
- [ ] Strong thirst (cold or hot)
- [ ] Thirst, no desire to drink
- [ ] Fatigue
- [ ] Sudden energy drop. Time of day? ____________________________
- [ ] Edema Where? ______________
- [ ] Poor sleeping
- [ ] Tremors
- [ ] Poor balance
- [ ] Cravings
- [ ] Change in appetite
- [ ] Weight gain
- [ ] Weight loss

SKIN AND HAIR

- [ ] Rashes
- [ ] Itching
- [ ] Change in hair or skin
- [ ] Ulcerations
- [ ] Eczema
- [ ] Oozing of skin lesion
- [ ] Hives
- [ ] Pimples
- [ ] Recent moles
- [ ] Loss of hair
- [ ] Dandruff
- [ ] Other hair or skin problems: ____________________________

HEAD, EYES, EARS, NOSE & THROAT

- [ ] Dizziness
- [ ] Migraines
- [ ] Headaches
  When? ____________ Where? ________________
- [ ] Facial pain
- [ ] Glasses
- [ ] Poor vision
- [ ] Night blindness
- [ ] Blurry vision
- [ ] Color blindness
- [ ] Blind field
- [ ] Spots in front of eyes
- [ ] Eye pain
- [ ] Eye strain
- [ ] Cataracts
- [ ] Eye dryness
- [ ] Excessive tearing
- [ ] Discharge from eyes
- [ ] Poor hearing
- [ ] Ringing in ears
- [ ] Earaches
- [ ] Discharge from ear
- [ ] Nose bleeds
- [ ] Sinus congestion
- [ ] Nasal drainage
- [ ] Grinding teeth
- [ ] Teeth problems
- [ ] Jaw clicks
- [ ] Concussion
- [ ] Recurrent sore throats
- [ ] Hoarseness
- [ ] Sores on lips or tongue
- [ ] Other head or neck problems
  ____
  ____

HEALTH HISTORY QUESTIONNAIRE – PAGE 4

Name ____

Please check any of the following symptoms you have had
Within the Last Three Months:

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems:

____

RESPIRATORY
- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Pain with a deep breath
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm. What color?

____

- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other lung problems:

____

GASTROINTESTINAL
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems:

____

GENITO-URINARY
- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals
- ☐ Do you wake up to urinate? ☐Yes ☐ No
  Any particular color to your urine? ___________
- ☐ Other urinary system problems: ______________

____

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Muscle pains
- ☐ Muscle weakness

PREGNANCY & GYNECOLOGY
- ☐ Number of pregnancies ___________
- ☐ Number of births _______________
- ☐ Premature births ________________
- ☐ Miscarriages ___________________
- ☐ Abortions _____________________
- ☐ Age at first menses ______________
- ☐ Number of days between menses ____
- ☐ Duration of menses ______________
- ☐ First date of last menses ___________
- ☐ Unusual character of flow: ☐Heavy ☐ Light
  Number of pads/tampons per day __________
  Color of flow: ☐ Light red ☐ Red
  ☐ Dark Red ☐ Purple
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots

HEALTH HISTORY QUESTIONNAIRE – PAGE 5

Name ____

Please check any of the following symptoms you have had
Within the Last Three Months:

PREGNANCY & GYNECOLOGY (continued)

- ☐ Menopause: What age? ____________
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Post-coital bleeding
- ☐ Vaginal sores
- ☐ Last Pap test (date) _______________
- ☐ Breast lumps/fibroids
- ☐ Nipple discharge
- ☐ Do you practice birth control? ☐Yes ☐No
  What type & for how long? _____________
  ____
- ☐ Have you ever been diagnosed with:
  - ☐ Fibroids
  - ☐ Fibrocystic breasts
  - ☐ Endometriosis
  - ☐ Ovarian cysts
  - ☐ PID (Pelvic Inflammatory Disease)
  - ☐ Polycystic Ovary Syndrome

REPRODUCTIVE (MALE)

- ☐ BPH (Benign Prostatic Hypertrophy)
- ☐ Pain or ache after orgasm
- ☐ Difficulty maintaining erection
- ☐ Premature ejaculation

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Loss of control/violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse
- ☐ Other neurological or psychological problems:
  ____
  ____
- ☐ Have you ever been treated for emotional problems? ☐Yes ☐No
- ☐ Have you ever attempted or considered suicide? ☐Yes ☐No

Additional concerns you would like to discuss:

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