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 any questions, please ask. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the comments section. Thank you.

NAME: (FIRST) (MIDDLE INT) (LAST)			HOME PHONE: OR Cell Phone:				
ADDRESS:			WORK PHONE:				
CITY:	STATE:	ZIP:	OCCUPATION:				
PLACE OF BIRTH:	DATE OF BIRTH:		AGE:	SEX:	HT:	WT:	MARITAL STATUS:
FAMILY PHYSICIAN:		PHONE:					
IN EMERGENCY NOTIFY:		PHONE:					
REFERRED BY:							
INSURANCE CO:		POLICY #:					
HAVE YOU EVER BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE?							

Main problem(s) 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 daily activities (work, sleep, sex)?___________________________

Have you ever been diagnosed for this problem? If so, what?___________________________

What kind of treatments have you tried?___________________________

Past medical history (please include dates):___________________________

Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Heart Disease
Rheumatic Fever Thyroid Disease Seizures Venereal Disease
Other:___________________________

Surgeries:___________________________

Significant Trauma (auto accident, falls, etc.):___________________________

Birth History (when you or your child/children were born that caused significant trauma to you such as prolonged labor, forceps delivery, etc.):____

____

Allergies (drugs, chemicals, foods):____

____

Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures AsthmaAllergies Other:____

Medications taken within the last two months (vitamins, drugs, herbs, etc.):______________________

____

____

Occupational Stress (chemical, physical, psychological, etc.):______________________

____

Do you have a regular exercise program?_____If so, please describe:______________________

____

Have you ever been on a restricted diet?______ If so, what kind?______________________

____

Please describe your average daily diet:
Morning:____
Afternoon:____
Evening:____

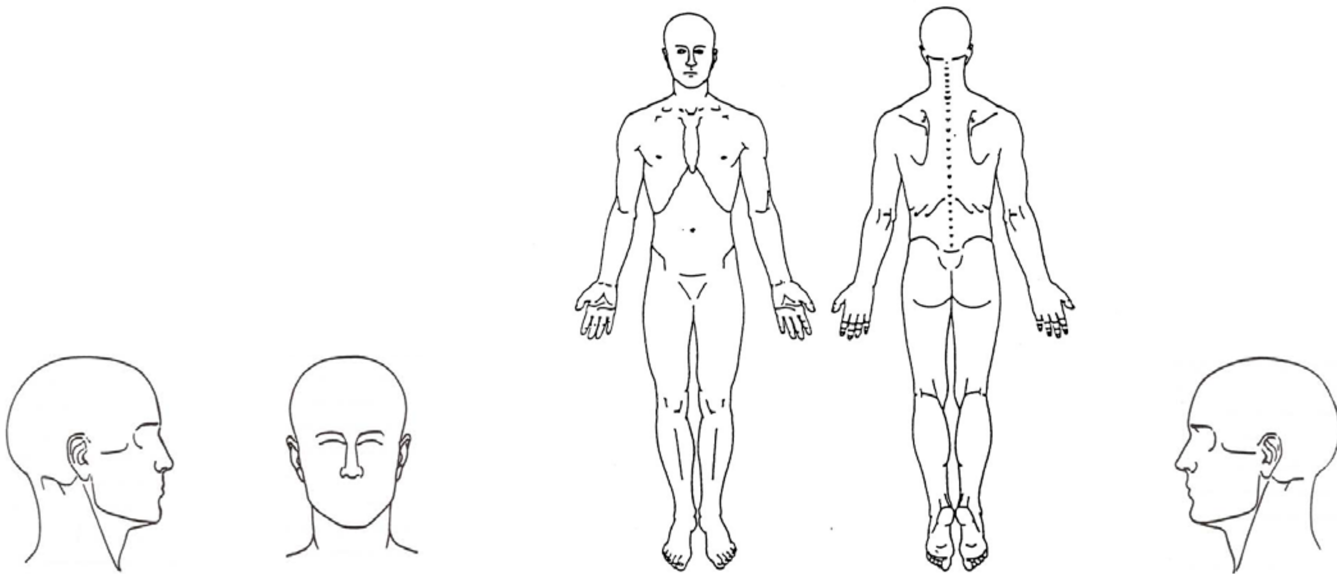
Do you smoke?_______If so, how many packs a day?______________________

How much coffee, tea, or soda do you drink per week?______________________

How much alcohol do you drink per week?______________________

Please describe any use of drugs for non-medical purposes:______________________

Indicate painful or distressed areas:



Please check if you have had (in the last three months):

GENERAL

- ☐ Poor appetite
- ☐ Poor sleeping
- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat easily
- ☐ Tremors
- ☐ Cravings
- ☐ Localized weakness
- ☐ Poor balance
- ☐ Change in appetite
- ☐ Bleed or Bruise easily
- ☐ Weight loss
- ☐ Weight gain
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop (What time of day)?
- ☐ Strong thirst (cold or hot drinks)

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Change in skin or hair textures

Any other skin or hair problems? ____

HEAD, EYES, EARS, NOSE, & THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor Hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurring soar throat
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Sore on lips or tongue
- ☐ Teeth problems
- ☐ Jaw clicks

Headaches (where and when)? ____

Any other head or neck problems? ____

CARDIVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Difficulty in breathing

Any other heart or blood vessel problems? ____

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep breathe
- ☐ Difficulty breathing while lying down
- ☐ Production of phlegm (what color?)______________________

Any other lung problems? ____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with your stomach or intestines? ______________________________

GENITO-URINARY

- ☐ Pain in urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotency
- ☐ Sores on genitals

Do you wake up to urinate?________________How often?_______________________

Any particular color to your urine? ______________________________

Any other problems with your genital or urinary system? ______________________________

PREGNANCY & GYNECOLOGY

- __ Number of pregnancies
- __ Number of births
- __ Premature births
- __ Number of miscarriages
- __ Number of abortions
- __ Age of first menses
- __ Period between menses
- __ Duration
- ☐ Unusual characters (heavy or light)
- ☐ Clots
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal sores
- ☐ Last PAP
- ☐ Vaginal discharge
- ☐ Breast Lumps
- ☐ Changes in body/psyche prior to menstruation

First date of last menses________________

Do you practice birth control?______________What type and for how long?_____________________________

MUSCULOSKELETAL

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

Any other joint or bone problems? ______________________________

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problems?______________________________

Have you ever considered or attempted suicide?______________________________

Any other neurological or psychological problems? ______________________________

COMMENTS

Please list any other problems you would like to discuss:______________________________

____

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