

Health History Questionnaire

Please help us provide you with a complete evaluation of your health by taking the time to fill out this questionnaire carefully. **All of your answers are held absolutely confidential.** If you have 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 _____		Date _____	
Address			
Street _____		City _____	State _____ Zip _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Date of Birth _____	Height _____ Weight _____
Marital Status _____		Occupation _____	Referred by _____
Home Phone: _____		Daytime Phone: _____	
Email Address _____			
In Emergency Notify: _____		Phone: _____	
Family Physician/phone # _____			

Main problem(s) you would like treatment for today? _____ _____
How long ago did this problem begin? _____
To what extent does this problem interfere with your daily activities, such as work, sleep, and exercise? _____
Have you been given a diagnosis for this problem? If so, what? _____
What kind of treatment(s) have you tried? _____ _____
Have you been treated by acupuncture before: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgeries (please include date of procedure) _____ _____
Significant trauma (physical or emotional) _____ _____
Allergies (drugs, chemicals, foods) _____ _____

Personal History		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> High/ Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Liver/Gall Bladder Disease	<input type="checkbox"/> Infertility
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Elevated Blood Cholesterol	<input type="checkbox"/> Raynaud's Disease

Patient Name _____ Date _____

Family Medical History (please indicate relationship to self)

Diabetes Cancer High Blood Pressure Heart Disease Stroke
Seizures Asthma Allergies Other:

Medicines taken in the last 2 months (pharmaceuticals, herbs, vitamins) Please include doses

Do you have a regular exercise program? No Yes, please describe _____

Have you been on a restricted diet? No Yes, when and what kind? _____

Do you smoke? No Yes, how much? _____

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

How much water do you drink per day? _____

How much alcohol per week do you drink? _____

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

Please check if you have had any of these items in the past 3 months

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Peculiar taste/smells | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Sudden energy drop, if yes time of day _____ | | |

Skin & Hair

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | | |
| <input type="checkbox"/> Other _____ | | |

Head, eyes, ears, nose and throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats |

Patient Name _____ Date _____

Head, eyes, ears, nose and throat cont'd

- | | | |
|--|--|--|
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Jaw clicks/Locks | <input type="checkbox"/> Headaches(where/when) _____ | |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Bleeding Gums | |
| <input type="checkbox"/> Other head or neck problems _____ | | |

Cardiovascular

- | | | |
|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Difficulty in breathing | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Spontaneous Sweating |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose/spider veins |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Palpitations at rest | |
| <input type="checkbox"/> Other heart or blood vessel problems | | |

Respiratory

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> Tightness in Chest |
| <input type="checkbox"/> Other respiratory problems | | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Black stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain/cramping | <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Acid reflux/GERD |
| <input type="checkbox"/> IBS/Crohn's Disease | <input type="checkbox"/> >2 stools/day | |
| <input type="checkbox"/> Other stomach/intestinal problems | | |

Genital-Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Impotency | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Other genital/urinary problems _____ | |

Patient Name _____ Date _____

Musculoskeletal		
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Knee pain
<input type="checkbox"/> Back pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Foot/ankle pains
<input type="checkbox"/> Hand/wrist pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Hip pain
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Rotator Cuff	
Other musculoskeletal problems _____		

Neuropsychological		
<input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Areas of Numbness	<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Poor memory
<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Easily susceptible to stress	<input type="checkbox"/> Bad temper	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Seasonal Affective Disorder		
Have you ever been treated for emotional problems? _____		
Have you ever considered suicide? _____		
<input type="checkbox"/> Other neurological/psychological problems _____		

Reproductive and Gynecologic		
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Clotting with menses	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> PMS	<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Polycystic Ovarian Disease
<input type="checkbox"/> Infertility	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Difficult/Painful intercourse
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> # of pregnancies _____	<input type="checkbox"/> # Live Births _____	<input type="checkbox"/> # Miscarriages _____
<input type="checkbox"/> # of abortions _____	<input type="checkbox"/> # Premature births _____	
Age of First Menses _____	Days between menses _____	Duration of menses _____
Age of Menopause _____	Last PAP _____	
Do you practice birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes/what kind _____		
Is there a chance that you are currently pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes		

Comments:

Please tell us of any other problems you would like to discuss or have the practitioner made aware of.
