

HEALTH HISTORY QUESTIONNAIRE

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 which is not asked on this form, please note it in the "Comments" section. Thank you.

Date

Name	Cell phone	Work phone		
Email	Home phone			
Street	City	State/Zip		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight
Occupation	Employer		Physician	
Emergency Contact - Name (First & Last)	Emergency Contact - Phone		Relation to you	

Have you been treated by acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep, and sex?
Have you been given a diagnosis for this problem? If so, what?
What other kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include date) Significant Illnesses <i>(please circle all applicable)</i>
Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever
Thyroid Disease Seizures Venereal Disease Other (please specify):
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

Family Medical History (please circle all applicable)

Asthma Allergies Diabetes Cancer Heart Disease High Blood Pressure
Stroke Seizures Thyroid Other (please specify):

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

Occupational stress (chemical, physical, psychological, etc.)

Do you have a regular exercise program? If yes, please describe.

Have you ever been on a restricted diet? If yes, what kind?

Please describe your average daily diet:

Morning:	Afternoon:	Evening:

Do you smoke? If yes, how much?

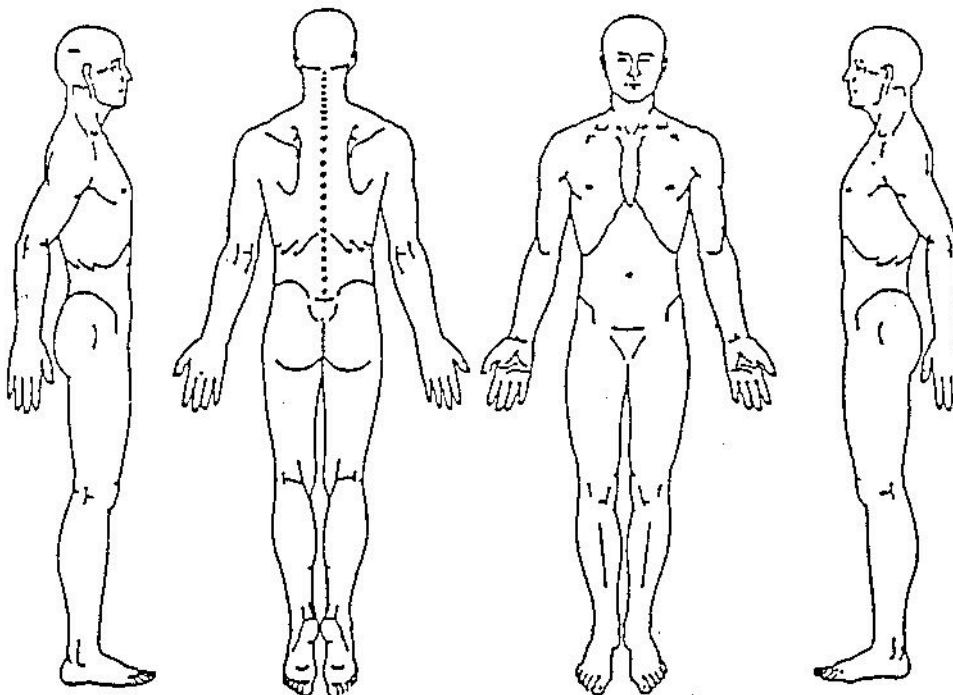
How much caffeinated coffee, tea, or cola do you drink per week?

How much water do you drink per day?

How much alcohol do you drink?

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

Please indicate any painful or distressed areas by circling the area.



Name: _____ Date: _____

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

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst (hot or cold drinks) |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Cravings | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sudden energy drop (time of day?) |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight gain | |

Skin & Hair

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <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"/> Any other hair or skin problems? | | |

Head, eyes, ears, nose, and throat

- | | | |
|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Color 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 |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (where, when?) |
| <input type="checkbox"/> Any other head or neck problems? | | |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Peripheral Arterial Sclerosis |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

Respiratory

- | | | |
|---|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Pain with a deep breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Wheezing while breathing | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficulty in breathing when lying down | |
| <input type="checkbox"/> Production of phlegm. What color? | | |
| <input type="checkbox"/> Any other lung/breathing problems? | | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Any other problems with your stomach or intestines? | | |

Urinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Any particular color to your urine: |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decrease in flow | |
| <input type="checkbox"/> Do you wake up to urinate? How often? | | |
| <input type="checkbox"/> Any other problems with your or urinary system? | | |

Male Reproductive

- | | | |
|---|--|---|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Testicular pain/injury |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Spermatorrhea | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Low motility | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Any other reproductive problems? | | |

Female Reproductive*Are you pregnant?*

Yes No

Is it possible that you are pregnant?

Yes No

- | | | |
|---|--|---|
| <input type="checkbox"/> Age of first menses: _____ | <input type="checkbox"/> Pregnancies #: _____ | <input type="checkbox"/> Menopause Age: _____ |
| <input type="checkbox"/> Duration of menses: _____ | <input type="checkbox"/> Live births #: _____ | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Time between menses: _____ | <input type="checkbox"/> Premature births #: _____ | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Miscarriages #: _____ | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Abortions #: _____ | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Unusual character (heavy/light) | <input type="checkbox"/> Infertility | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Western Fertility Treatment | <input type="checkbox"/> |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? | | |
| <input type="checkbox"/> Any other reproductive problems? | | |

Musculoskeletal

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Foot/ankle pains |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Any other muscle, joint or bone problems? | | |

Neurological

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Tremors (where?) |
| <input type="checkbox"/> Any other neurological problems? | | |

Psychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Easily angered | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Overly joyful |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Easily over worried | |
| Have you ever been treated for emotional problems? | | |
| Have you ever considered or attempted suicide? | | |
| <input type="checkbox"/> Any other neurological or psychological problems? | | |

COMMENTS:

Please briefly tell us of any other problems you would like to discuss.
