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 (First & Last)	Home phone	Work phone	
Street	City	State/Zip	
Date of Birth	Age	Height	Weight
Occupation	Family Physician	Referred By	
Emergency Contact - Name (First & Last)	Emergency Contact - Phone	Relation to you	

Have you been treated by acupuncture or Oriental medicine before? ▫Yes ▫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 *(please circle all applicable)*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

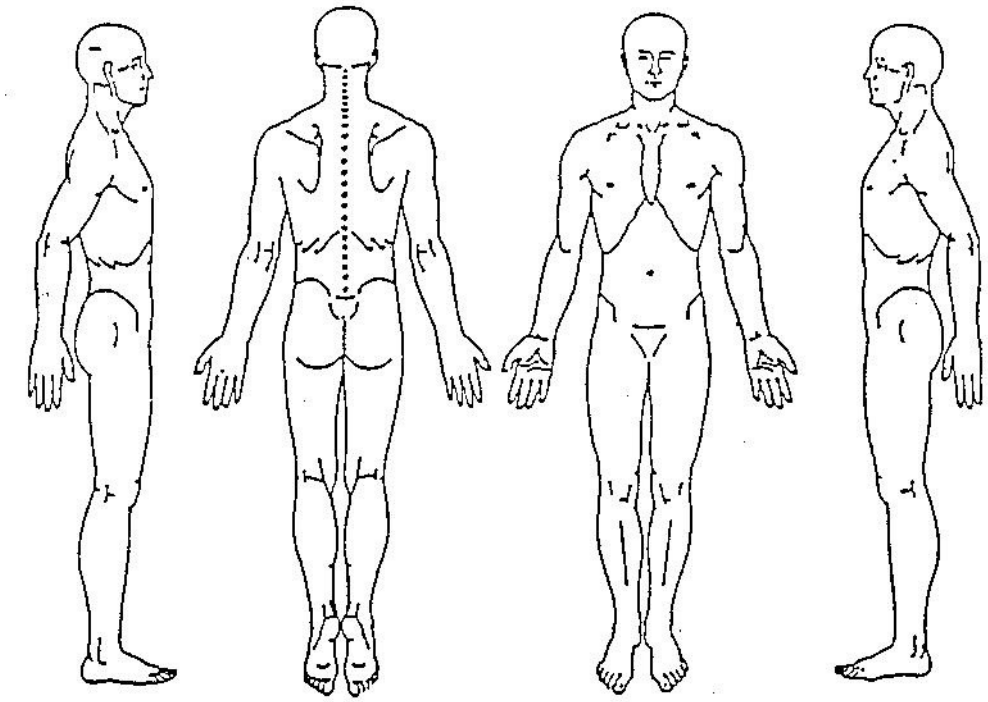
Thyroid Disease Seizures Venereal Disease Other (please specify):

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

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

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches (where, when?)

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling of feet
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Stroke
- ☐ Any other heart or blood vessel problems?

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Coughing blood
- ☐ Difficulty breathing
- ☐ Pain with a deep breath
- ☐ Bronchitis
- ☐ Wheezing while breathing
- ☐ Pneumonia
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm. What color?
- ☐ Any other lung/breathing problems?

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bleeding gums
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Any other problems with your stomach or intestines?

Genito-Urinary

- ☐ Frequent urination
- ☐ Pain upon urination
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Blood in urine
- ☐ Any particular color to your urine:
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Do you wake up to urinate? How often?
- ☐ Any other problems with your genital or urinary system?

Male Reproductive

- ▫ Impotency
- ▫ Prostatitis
- ▫ Testicular pain/injury
- ▫ Premature Ejaculation
- ▫ Prostate Cancer
- ▫ Testicular Cancer
- ▫ Spermatorrhea
- ▫ Benign Prostatic Hypertrophy
- ▫ Sores on genitals
- ▫ STDs
- ▫ Any other reproductive problems?

Female Reproductive and gynecologic

Are you pregnant? Yes No

Is it possible that you are pregnant? Yes No

- ▫ Pregnancies #: _____
- ▫ Live births #: _____
- ▫ Miscarriages #: _____
- ▫ Abortions #: _____
- ▫ Premature births #:_____
- ▫ Age of first menses: _____
- ▫ Time between menses: ____
- ▫ Duration of menses: ____
- ▫ Unusual character (heavy, light)
- ▫ Irregular periods
- ▫ Painful periods
- ▫ Clots
- ▫ Last PAP
- ▫ Vaginal discharge
- ▫ Vaginal sores
- ▫ Breast lumps
- ▫ Menopause Age: _____
- ▫ STDs
- ▫ Changes in body/psyche prior to menstruation
- ▫ Do you practice birth control? What type and for how long?
- ▫ Any other reproductive problems?

Musculoskeletal

- ▫ Neck pain
- ▫ Muscle pain
- ▫ Knee pain
- ▫ Back pain
- ▫ Muscle weakness
- ▫ Foot/ankle pains
- ▫ Hand/wrist pains
- ▫ Shoulder pain
- ▫ Hip pain
- ▫ Any other joint or bone problems?

Neuropsychological

□ Seizures	□ Dizziness	□ Loss of Balance
□ Stroke	□ Areas of numbness	□ Poor memory
□ Concussion	□ Depression	□ Anxiety
□ Bad temper	□ Easily susceptible to stress	□ Lack of coordination

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

□ Any other neurological or psychological problems?

COMMENTS:

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