

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	

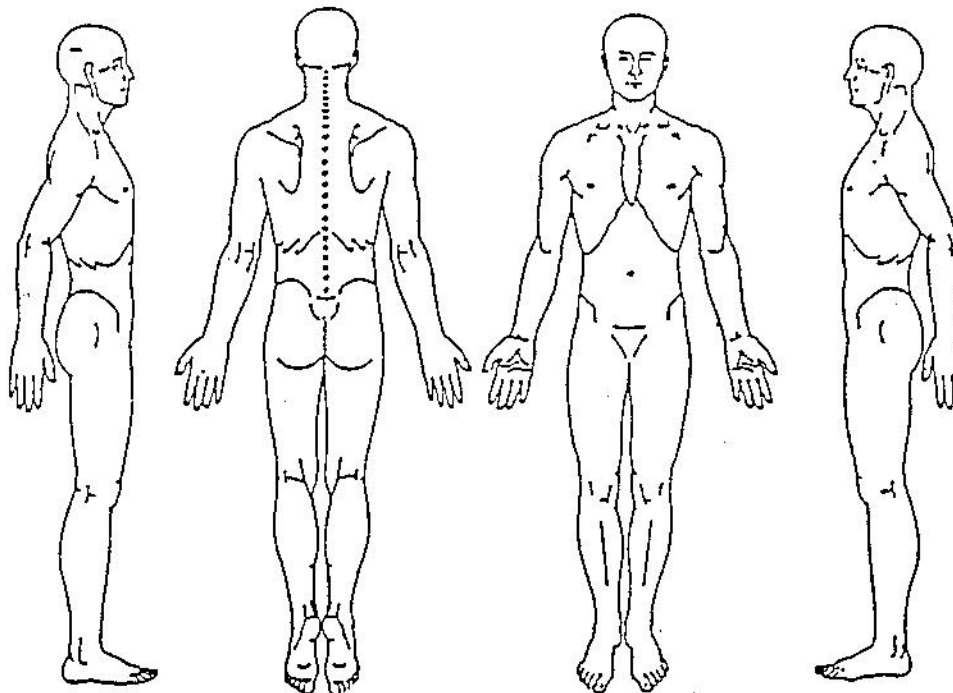
Have you been treated by acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, 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?

PASTMEDICAL 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
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

Family Medical History (please circle all applicable)					
Diabetes	Cancer	High Blood Pressure	Heart Disease	Stroke	Seizures
Asthma	Allergies	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? 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"/> Poor sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst (hot or cold drinks) | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden energy drop (what time of day?) | | <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"/> 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 | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

Respiratory

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

