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	E-mail:

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):

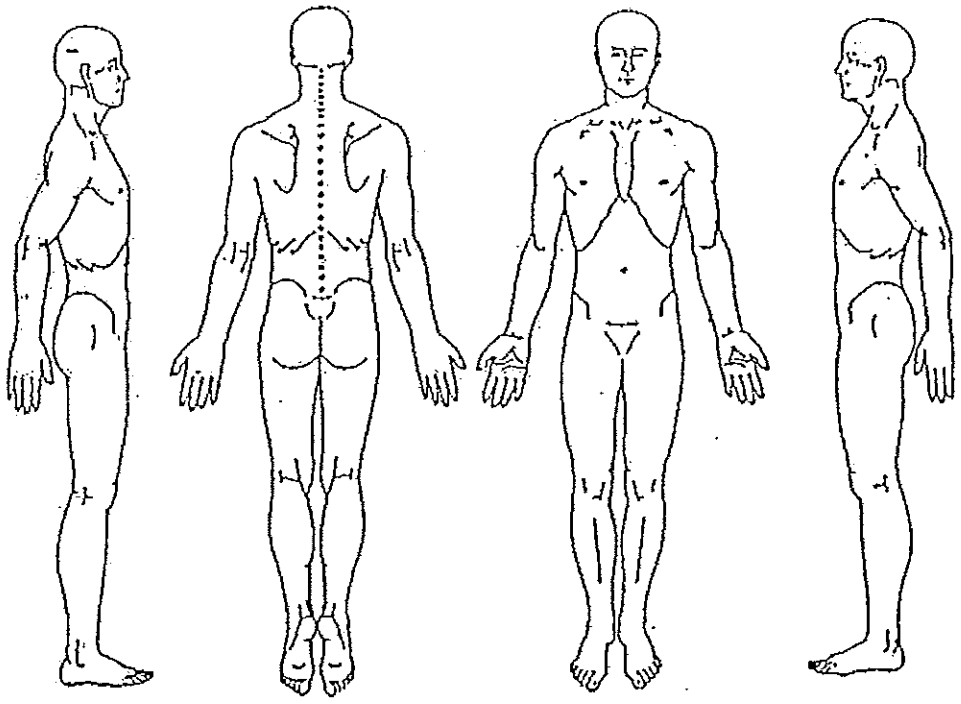
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

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 sleep
- ☐ 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

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

Respiratory

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

Gastrointestinal

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

Urinary

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

Male Reproductive

- ☐ Impotence
- ☐ Prostatitis
- ☐ Prostate Cancer
- ☐ Benign Prostatic Hypertrophy
- ☐ Premature Ejaculation
- ☐ Spermatorrhea
- ☐ Low sperm count
- ☐ Low motility
- ☐ Testicular pain/injury
- ☐ Testicular Cancer
- ☐ Sores on genitals
- ☐ STDs
- ☐ Any other reproductive problems?

Female Reproductive

Are you pregnant? Yes No
Is it possible that you are pregnant? Yes No

- ☐ Age of first menses: _____
- ☐ Duration of menses: _____
- ☐ Time between menses: _____
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Unusual character (heavy/light)
- ☐ Clots
- ☐ Pregnancies #: _____
- ☐ Live births #: _____
- ☐ Premature births #: _____
- ☐ Miscarriages #: _____
- ☐ Abortions #: _____
- ☐ Infertility
- ☐ Western Fertility Treatment
- ☐ Menopause Age: _____
- ☐ Last PAP
- ☐ Vaginal discharge
- ☐ Breast lumps
- ☐ Sores on genitals
- ☐ 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
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Any other muscle, joint or bone problems?

Neurological

- ☐ Seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Lack of coordination
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Tremors (where?)
- ☐ Any other neurological problems?

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Fearful
- ☐ Easily angered
- ☐ Easily susceptible to stress
- ☐ Easily over worried
- ☐ Sadness
- ☐ Overly joyful

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.