

HEALTH HISTORY QUESTIONNAIRE

*Please help me to provide you with a complete evaluation by taking the time to fill this form out carefully .
All of your answers will be held confidential, unless you sign an authorization form for your records to be released.

| | | |
|-------|----------|-------------------------|
| Name: | Date: | |
| Age: | Sex: M F | Marital Status: S M D W |

| |
|---|
| Have you ever received acupuncture treatments before? Y N |
| What Health concern(s) would you like to address today? |
| |
| |
| How long ago did this/these concern(s) begin? |
| Is there a known cause or instigating factor for this/these concern(s)? |
| |
| |
| Have you seen a doctor for this/these concern(s)? |
| |
| What treatments have you tried? |
| |
| |
| What if anything has helped this condition? |
| |
| |
| What if anything aggravates this condition? |
| |
| |
| List any significant traumas and approximate dates (auto accidents, injuries, emotional traumas etc.) |
| |
| |
| List any surgeries that you have had (include dates) |
| |
| |
| List medications that you are taking (including supplements and vitamins) |
| |
| |
| Please list any allergies (including drugs or medications) |
| |
| |

Do you smoke? Y N
If yes, how much per day?

Alcohol: How much per day?

Nutrition:

What do you typically eat for the following:

| |
|------------|
| Breakfast: |
| Lunch: |
| Dinner: |

Exercise:

What is your daily activity level related to you occupation?

- sedentary, (ie mostly sitting) - somewhat active - moderately active
 - very active(i.e. moving around or up most of the time) - heavy duty (i.e. lifting, moving things)

Miscellaneous:

How much water do you drink each day?

How much caffeinated products do you drink each day? (coffee, tea, pop)

Female Patients: please fill out the following section

| |
|--|
| Pregnancy: are you currently pregnant? Y N |
| Please list history of pregnancy; note full term (FT), premature(P), miscarriage(M); whether vaginal(V) or cesarean©; |
| Note any difficulties relating to the pregnancy (i.e. edema, morning sickness, prolonged bleeding after delivery, depression |
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Menstruation:

| | | |
|---|----------------------------|-------------------------|
| Age at onset: | LMP/1st day of last cycle: | Length between periods: |
| Date of last Pap/exam: | Results: | |
| Regularity: <input type="radio"/> - regular <input type="radio"/> - Irregular <input type="radio"/> - usually early <input type="radio"/> - usually late <input type="radio"/> - Varies between being early or late | | |
| Length of flow: | | |
| Flow is: <input type="radio"/> - even <input type="radio"/> - uneven <input type="radio"/> - heavy <input type="radio"/> - light | | |
| Color is: <input type="radio"/> - pale <input type="radio"/> - pink <input type="radio"/> - red <input type="radio"/> - deep red <input type="radio"/> - purplish <input type="radio"/> - brown | | |
| Consistency is: <input type="radio"/> - thin <input type="radio"/> - thick <input type="radio"/> - clotted | | |
| Do you have PMS? If yes describe | | |
| Do you have discomfort during period? If yes describe | | |
| Menopause: | | |
| Age at onset: | Any difficulties,symptoms? | |

Male patients: please fill out the following section

Please check any of the conditions or symptoms that you presently have or have had in the past.

- Prostate enlargement
 - Prostatitis
 - Premature ejaculation
 - Impotence

Please indicate if you have experienced any of the following conditions or symptoms by Checking **P** for experienced in **Past** and **C** for **Currently** experiencing.

| P | C | General |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss |

Eyes, Ears

| P | C | Nose, Throat |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots in front of eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye strain |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataract |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus congestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Teeth problems |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent sore throats |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth or tongue sores |

| P | C | Respiratory |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Production of phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Tight chest |

| P | C | Skin and Hair |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives |
| <input type="checkbox"/> | <input type="checkbox"/> | Acne |
| <input type="checkbox"/> | <input type="checkbox"/> | Hair Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Dandruff |

| P | C | Cardiovascular |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart beat |

| P | C | Gastrointestinal |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart burn |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching |
| <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |

| P | C | Genito-Urinary |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgency to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | Discolored urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | Dribbling |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Impotency |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes of sex drive |
| <input type="checkbox"/> | <input type="checkbox"/> | STD |

| P | C | Neuro-Psych. |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of Coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily Stressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse |

| P | C | Musculoskeletal |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand/wrist pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot/ankle pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Limited range of motion |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain that moves |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor posture |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps |