



## Health History Questionnaire For Patients

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it on the comments

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cellphone: \_\_\_\_\_

Date/Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Occupation \_\_\_\_\_

Marital Status: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_

Referred by: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Have you tried acupunctue or Chinese herbal medicine before? \_\_\_\_\_

### WHAT IS YOUR MAIN CONCERN?

\_\_\_\_\_

To what extent does this problem affect your daily activities ( work, sleep, eating, etc.) ?

\_\_\_\_\_

How long has it been since you first noticed any symptoms?

\_\_\_\_\_

Have you been given a diagnosis for the problem by your family physician?

\_\_\_\_\_

If so, what is it?

\_\_\_\_\_

What kinds of treatment or therapy have you tried?

### PAST MEDICAL HISTORY ( PLEASE INCLUDE DATES )

Allergies

Cancer

Diabetes

Hepatitis

High blood pressure

Heart disease

Seizures

Rheumatic fever

Surgeries

Venereal disease

Thyroid disease

Birth trauma ( prolonged  
labor, forceps delibery, etc. )

Other significant illness  
(describe) \_\_\_\_\_

Accidents or significate  
trama (describe) \_\_\_\_\_

### OTHER RELEVANT MEDICAL HISTORY



## FAMILY MEDICAL HISTORY

- |                                    |  |                                   |
|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other    |

## OCCUPATION

Occupational stress factors ( physical, psychological, chemical):

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## LIFESTYLE

Do you follow a regular exercise program? If so, please describe:

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Please describe your average daily diet:

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Please check any of the following habits that apply. How much and how often do you use them?

- Cigarette smoking                     
  Coffee, tea or cola                     
  Alcoholic beverages
- 

List medications taken within the last two months ( vitamins, drugs, herbs, etc. ):

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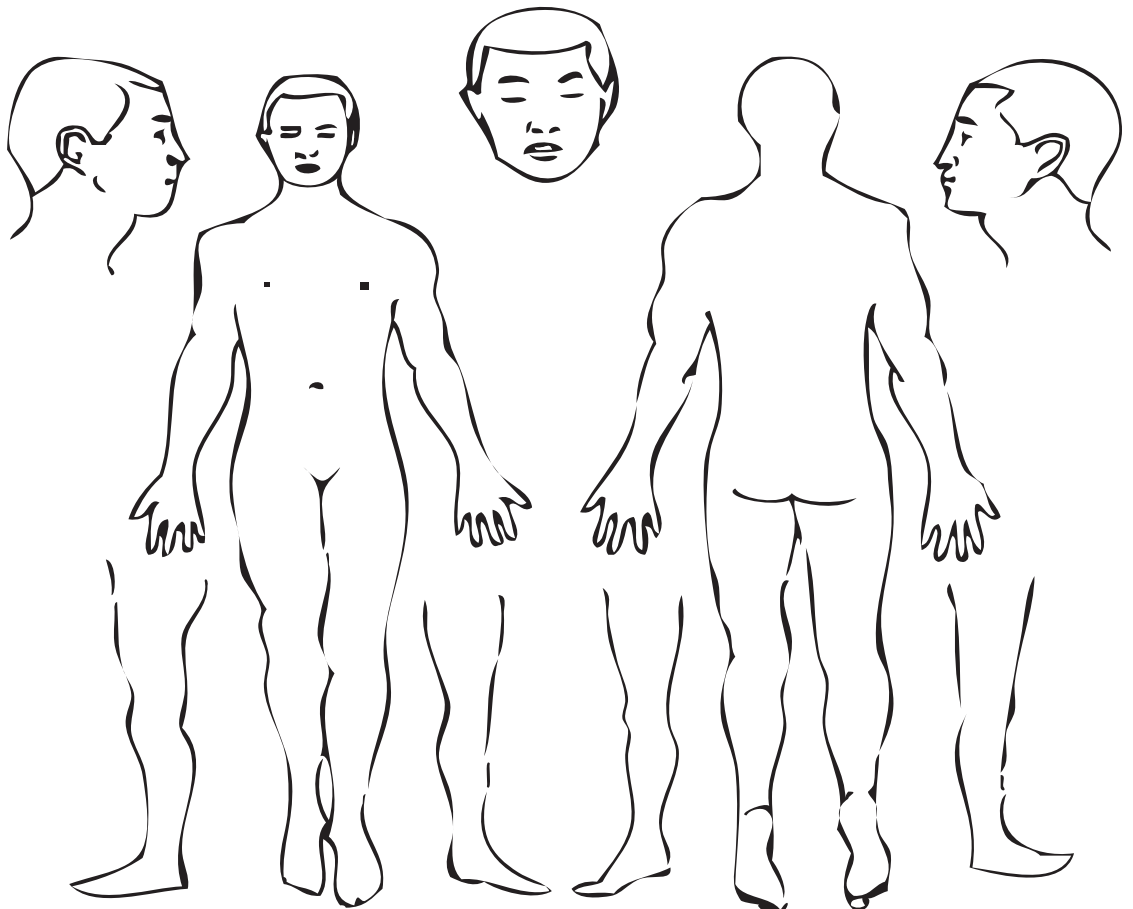
Please describe any use of drugs for non-medical puposes:

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### PLEASE PUT A

| Symbol                  | Reaction |
|-------------------------|----------|
| <b>Pain on pressure</b> |          |
| x                       | little   |
| xx                      | moderate |
| xxx                     | strong   |
| <b>Swelling</b>         |          |
| ^                       | slight   |
| ^^                      | moderate |
| ^^^                     | severe   |
| <b>Tension/weakness</b> |          |
| ≈                       | week     |
| #                       | tense    |
| <b>Spontaneous pain</b> |          |
| †                       | slight   |
| ††                      | moderate |
| †††                     | severe   |
| <b>Pulsing</b>          |          |
| o                       | slight   |
| oo                      | moderate |
| ooo                     | strong   |
| <b>Temperature</b>      |          |
| -                       | colder   |
| +                       | hotter   |
| <b>Physical</b>         |          |
| ∅                       | sores    |
| *                       | rashes   |
| << >>                   | spasms   |

### PLEASE MARK PAINFUL OR DISTRESSED AREAS OF THE CHARTS BELOW





CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS.  
INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION

### GENERAL

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor appetite      | <input type="checkbox"/> Weight gain                 | <input type="checkbox"/> Night sweats       |
| <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Weight loss                 | <input type="checkbox"/> Fever              |
| <input type="checkbox"/> Disturbed sleep    | <input type="checkbox"/> Changes in appetite         | <input type="checkbox"/> Chills             |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily             | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Cravings           | <input type="checkbox"/> Tremors                     | <input type="checkbox"/> (time of day?)     |
| <input type="checkbox"/> Strong thirst      | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Poor balance       |

Other unusual or abnormal conditions you have noticed in your general sense of health?

### SKIN AND HAIR

- |                                      |                                    |   |
|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Recent moles                         |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples   | <input type="checkbox"/> Change in texture of hair<br>or skin |
| <input type="checkbox"/> Hives       | <input type="checkbox"/> Dandruff  |   |
| <input type="checkbox"/> Itching     | <input type="checkbox"/> Hair loss |   |

Any other hair or skin problems?

### HEAD, EYES, EARS, NOSE, THROAT

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Recurring sore throats   |
| <input type="checkbox"/> Concussion             | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Nose bleeds              |
| <input type="checkbox"/> Migraines              | <input type="checkbox"/> Blurry vision   | <input type="checkbox"/> Grinding teeth           |
| <input type="checkbox"/> Glasses                | <input type="checkbox"/> Earaches        | <input type="checkbox"/> Sores on lips or tongue  |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Facial pain              |
| <input type="checkbox"/> Eye pain               | <input type="checkbox"/> Poor hearing    | <input type="checkbox"/> Teeth problems           |
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Eye strain      | <input type="checkbox"/> Headaches (where? when?) |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Jaw clicks               |

Any other head or neck problems?

### CARDIOVASCULAR

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet        |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Blood clots             |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands   | <input type="checkbox"/> Phlebitis               |

Any other heart or blood vessel problems?

### RESPIRATORY

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cough             | <input type="checkbox"/> Bronchitis                | <input type="checkbox"/> Difficulty breathing when<br>lying down |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Excessive phlegm (color?)               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Pneumonia                 |  |

Any other lung problems?



### GASTROINTESTINAL

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Belching        | <input type="checkbox"/> Rectal pain              |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Black stools    | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion     | <input type="checkbox"/> Chronic laxative use     |
| <input type="checkbox"/> Gas          | <input type="checkbox"/> Bad breath      |   |

Any other problems with stomach or intestines?

### GENITOURINARY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on urination            | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Urgent or frequent urination | <input type="checkbox"/> Decrease in flow     | <input type="checkbox"/> Impotence         |
| <input type="checkbox"/> Blood in urine               | <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Sores on genitals |

Do you wake up at night to urinate?

If so, how often?

Any particular color to your urine?

Any other genital or urinary problems?

### REPRODUCTIVE AND GYNECOLOGIC

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Premenstrual changes | <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Menstrual clots      | <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Miscarriages     |
| <input type="checkbox"/> Painful menses       | <input type="checkbox"/> Irregular menses     | <input type="checkbox"/> Abortions        |
| <input type="checkbox"/> Unusual menses       | <input type="checkbox"/> Other problems       |   |

Age at first menses

Age at menopause

Number of pregnancies

Time between cycles

Duration of bleeding

First day of last menses

Do you practice birth control?

If so, what type?

For how long?

Any other gynecologic problems?

### MUSCULOSKELETAL

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Neck pain    | <input type="checkbox"/> Back pain        | <input type="checkbox"/> Hand/wrist pains |
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Muscle weakness  | <input type="checkbox"/> Shoulder pains   |
| <input type="checkbox"/> Knee pain    | <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Hip pain         |

Any other joint or bone problems?

### NEUROPSYCHOLOGICAL

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Anxiety                      |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Bad temper                   |
| <input type="checkbox"/> Loss of balance   | <input type="checkbox"/> Concussion           | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression           |   |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

### COMMENTS

Please list any other problems you would like to discuss: