

# Health History Questionnaire

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please help me 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, unless you sign a waiver allowing your records to be released. If you have any questions, please ask. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments Section on page 4.

Name:		Work Phone ( ) -		Home Phone: ( ) -	
Address:			City:		State:
Zip Code:		Social Security Number:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Age:
Date of Birth: / /		Place of Birth:		Height:	Weight:
Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Living with Partner, Unmarried <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Email:	
Employer Name:			Occupation:		
Education (mark highest level achieved): <input type="checkbox"/> Grade School or Less <input type="checkbox"/> Some College <input type="checkbox"/> Some High School <input type="checkbox"/> College Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Graduate or Professional School <input type="checkbox"/> Vocational or Technical School					
Family Physician: Dr. Name and Clinic Name			Referred by:		
In case of Emergency contact (Name):			Emergency Contact Phone: Day ( ) - Eve ( ) -		
Have you been treated by acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No					

What is/are the main problem(s) you would like us to help you with: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long ago did this problem begin (be specific)?: \_\_\_\_\_  
 \_\_\_\_\_

Was there a known cause/instigating factor for your problem? \_\_\_\_\_  
 \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex)?: \_\_\_\_\_  
 \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what?: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What kinds of treatment have you tried?: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Past Medical History (please include date):  Cancer \_\_\_\_\_  Diabetes \_\_\_\_\_  Hepatitis \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  Heart Disease \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  
 Thyroid Disease \_\_\_\_\_  Seizures \_\_\_\_\_  Venereal Disease \_\_\_\_\_  
 Other: \_\_\_\_\_

Surgeries (type of and date): \_\_\_\_\_  
 \_\_\_\_\_

Significant Trauma (auto accidents, falls etc.): \_\_\_\_\_  
 \_\_\_\_\_

Significant Dental Work (type and date): \_\_\_\_\_  
 \_\_\_\_\_

Birth History (prolonged labor, forceps delivery, etc.): \_\_\_\_\_  
 \_\_\_\_\_

Allergies (drugs, chemicals, foods/result): \_\_\_\_\_  
 \_\_\_\_\_

Family Medical History (check):  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?  Yes  No Please describe: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been on a restricted diet?  Yes  No What kind?: \_\_\_\_\_  
 \_\_\_\_\_

**Please Describe Your Average Daily Diet**

Morning \_\_\_\_\_  
 Afternoon \_\_\_\_\_  
 Evening \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_ How much coffee, tea or cola do you drink per week? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_ Please describe any use of drugs for non-medical purposes: \_\_\_\_\_  
 \_\_\_\_\_

**Please Check Any Symptoms That have Been Persistent in the Last Three Months**

**General**

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
- Time of day? \_\_\_\_\_
- Poor sleeping

- Edema  
Where \_\_\_\_\_
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight gain
- Weight loss

**Skin and Hair**

- Rashes
- Itching
- Change in hair or skin

- Ulcerations
- Eczema
- Oozing on skin lesion
- Hives
- Pimples
- Recent moles
- Loss of hair
- Dandruff
- Other hair or skin problems: \_\_\_\_\_

**Head, Eyes, Ears, Nose And Throat**

- Dizziness

- Migraines
- Headaches  
When: \_\_\_\_\_  
Where: \_\_\_\_\_
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts

- Eye dryness
  - Excessive tear
  - Discharge from eyes
  - Poor hearing
  - Ringing in ears
  - Earaches
  - Discharge from ear
  - Nose bleeds
  - Sinus congestion
  - Nasal drainage
  - Grinding teeth
  - Teeth problems
  - Jaw clicks
  - Concussions
  - Recurrent sore throats
  - Hoarseness
  - Sores on lips or tongue
- Other head or neck problems:
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### CARDIOVASCULAR

- High blood pressure
  - Low blood pressure
  - Chest discomfort/pain
  - Heart palpitations
  - Cold hands or feet
  - Swelling of hands
  - Swelling of feet
  - Blood clots
  - Fainting
  - Difficulty in breathing
- Other heart or blood vessel problems:
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### RESPIRATORY

- Cough
  - Asthma/wheezing
  - Pain with a deep breath
  - Difficulty in breathing when lying down
  - Production of phlegm what color: \_\_\_\_\_
  - Coughing blood
  - Pneumonia
  - Bronchitis
- Other lung problems:
- 
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### GASTROINTESTINAL

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion

- Diarrhea
  - Constipation
  - Chronic laxative use
  - Blood in stools
  - Black stools
  - Abdominal pain or cramps
  - Gas
  - Rectal pain
  - Hemorrhoids
- Other stomach or intestinal problems:
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### GENITO-URINARY

- Pain on urination
  - Urgency to urinate
  - Frequent urination
  - Blood in urine
  - Decrease in flow
  - Unable to hold urine
  - Dribbling
  - Kidney stones
  - Impotency
  - Change of sexual drive
  - Sores on genitals
- Other genital or urinary system problems:
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Do you wake up to urinate?  
 Yes  No  
 How often?

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Any particular color to your urine?

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### PREGNANCY AND GYNECOLOGY

- Number of pregnancies \_\_\_\_\_
  - Number of births \_\_\_\_\_
  - Premature births \_\_\_\_\_
  - Miscarriages \_\_\_\_\_
  - Abortions \_\_\_\_\_
  - Age at first menses \_\_\_\_\_
  - Period between menses \_\_\_\_\_
  - Duration \_\_\_\_\_
- First date of last menses:  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Unusual character
    - heavy
    - light
  - Painful periods
  - Irregular periods
  - Changes in body/psyche prior to menstruation
  - Clots
  - Menopause:
    - Age \_\_\_\_\_
    - Year \_\_\_\_\_

- Vaginal discharge
  - Postcoital bleeding
  - Vaginal sores
  - Last Pap
  - Breast lumps
  - Nipple discharge
- Do you practice birth control?  
 Yes  No
- What type and for how long?
- 
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### MUSCULOSKELETAL

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pains
- Hip pain
- Knee pain
- Foot/ankle pains
- Muscle pains
- Muscle weakness

### NEUROPSYCHOLOGICAL

- Seizures
  - Areas of numbness
  - Weakness
  - Sleep disorder
  - Concussion
  - Bad temper
  - Loss of control/violence potential
  - Vertigo
  - Lack of coordination
  - Depression
  - Easily susceptible to stress
  - Loss of balance
  - Poor memory
  - Anxiety
  - Substance abuse
- Other neurological or psychological problems
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Have you ever been treated for emotional problems?  
 Yes  No

Have you ever considered or attempted suicide?  
 Yes  No

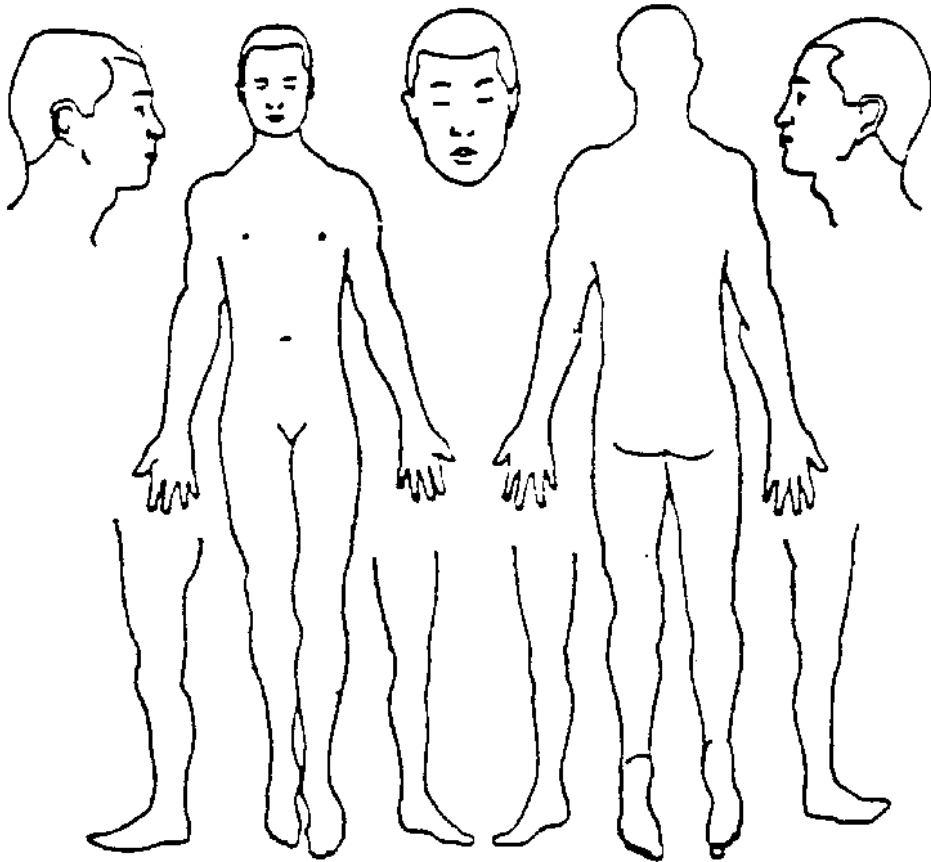
**Please note the degree of severity of your problem now:**



**Please note the greatest degree of severity of your problem within the last week:**



**Indicate painful or distressed areas:**



**Comments** (please tell us any other problems you would like to discuss): \_\_\_\_\_

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