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Acupuncturist and Chinese Herbalist

HEALTH HISTORY QUESTIONNAIRE

Name:____ Date: ____________

Address:____

Phone: (h): ___________________ Email address:______________________________

Emergency Contact & Number: ____

Date of Birth: _____/_____/_____ Age:______ Gender: M F Marital Status: S M D W

When and where did you last receive health care? ___________________________________

For what reason? ____

Please identify the health concerns that have brought you here in order of importance below:

Condition	**Past Treatment**
a. ________________________	________________________

How does this condition affect you? ________________________________

b. ________________________ ________________________

How does this condition affect you? ________________________________

c. ________________________

____

How does this condition affect you? ________________________________

d.________________________

____

How does this condition affect you? ________________________________

Please list any foods, medications or environmental substances you are hypersensitive / allergic to and their reactions:

____

____

Please list any medications (prescribed or over the counter), vitamins, herbs or supplements you are currently taking:

____

____

____

Do you have any reason to believe you might be pregnant? Y N

If so, how far along are you? ____

Do you have any infectious diseases? Y N If yes, please identify: ___________________

Blood Pressure: What is your most recent reading: ______/______ When was this reading? __________

Your height: __________ Your current weight: ________________

Childhood Illnesses (please circle any you may have had): Scarlet Fever Rheumatic Fever

Diphtheria Mumps Measles Chickenpox German measles Polio

Other : ____

Immunizations (please circle any you may have had): Polio Tetanus Pertusis
Diphtheria HIV Hepatitis B MMR Other:
____

Hospitalizations and Surgeries :

Reason When Reason When

____
____

____

____

In this section please *circle* any symptoms/conditions you experience now and *underline* any you have experienced in the past:

Emotional :

Mood Swings Nervousness Mental Tension Depression
Anxiety Stress

Energy and Immunity :

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts

Tearing/Dryness Impaired Hearing Ear Ringing Headaches Sinus
Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory:

Pneumonia Frequent Colds Difficulty Breathing Persistent
Cough

Shortness of Breath Other Respiratory Problems: ___________________________________

Cardiovascular :

Heart Disease Chest pain Swelling of Hands or Feet High Blood Pressure

Palpitations/ Flutter Stroke Heart Murmurs Varicose Veins
Rheumatic Fever

Other Cardiovascular Problems: ____

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain
Excess Gas

Heartburn Gallbladder Disease Liver Disease Hepatitis Hemorrhoids

Abdominal Pain Bloating Constipation Diarrhea Rectal Bleeding

Genito-Urinary:

Kidney Stones Kidney Disease Painful Urination Frequent Urination

Blood in Urine Frequent Urinary Infections Frequent Urination at Night

Menstrual/ Birthing History:

Irregular Cycle Breast Lumps/Tenderness Heavy Periods Vaginal Discharge

Menopausal Symptoms Premenstrual Problems Bleeding between Cycles Clotting

Painful Periods Infertility When was last Pap Smear? _________ Results:_____________

Female Reproductive: Age of First Menses?_______ # Days of Menses: _________

Length of Cycle: ______ Birth Control Type: ________ # of Pregnancies: ________

# of Miscarriages: ______ # of Live Births: ______ # of Abortions: ________

Male Reproductive:

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal:

Neck/ Shoulder Pain Upper Extremity Pain Lower Extremity Pain Muscle Weakness

Back Pain: Upper Mid Lower Joint Pain : Where: _________________________________

Neurologic :

Vertigo/Dizziness Paralysis Numbness/ Tingling Loss of Balance Seizures

Endocrine:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats

Feeling Hot/Cold

Other:

Anemia Cancer Eczema/Hives Cold Hands/ Feet

Is there anything else we should know? ____

____

Lifestyle:

Do you typically eat at least three meals a day? Y N If no, how many? ________________

Do you exercise? Y N If yes, how long/ how many days per week? _______ /___________

How many hours per night do you sleep? _____ Do you wake up during the night? Y N

Do you go back to sleep w/o problem? Y N Do you wake up rested? Y N

Occupation ___________________________ How many hours per week do you work? _______

Do you enjoy work? Y N Why/ Why not? ____

Nicotine/Alcohol/Caffeine Use: ____

Have you experienced any major trauma? Y N Explain: ______________________________

____

How many glasses of non-caffeinated, non- carbonated beverages do you drink a day? _________

Interests/ Hobbies ____