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:

Name	Phone	Email
Address		
Date of Birth	Age	Gender
Occupation	Family Physician	Referred By
Emergency Contact - Name	Relation to you	Emergency Contact - Phone

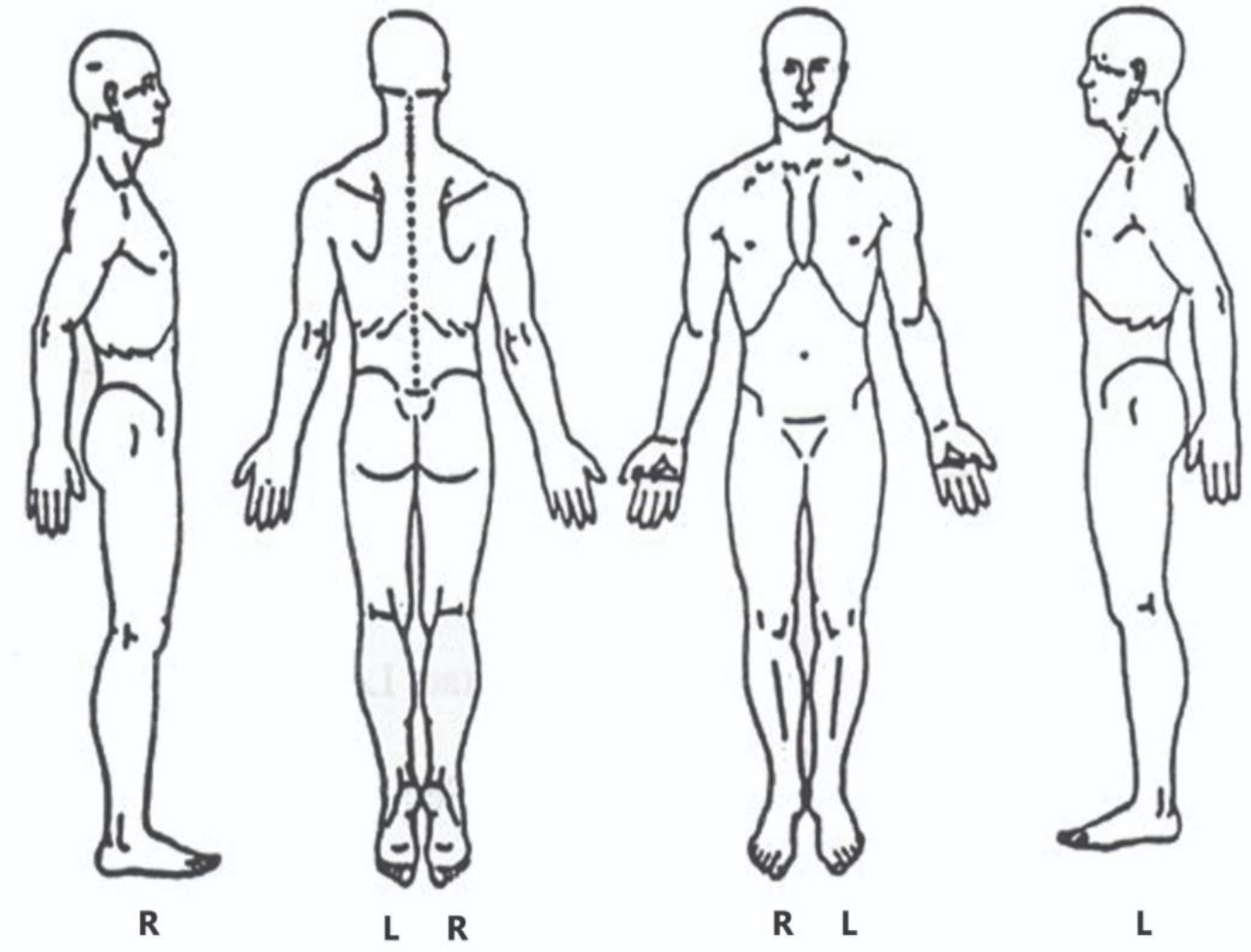
Have you been treated by acupuncture or oriental medicine before? ☐ Yes ☐ No
Main problem(s) you would like us to help you with
How long ago did this problem begin? Please be specific
To What extent does this problem interfere with your daily activities, such as work, sleep?
Have you been given a diagnosis for this problem? If so, what?
What other kind of treatments have you tried

Past Medical History (please include date) Significant illnesses (please circle all applicable) Cancer Diabetes Hepatitis High blood pressure Heart Disease Thyroid Disease Seizures Venereal Disease Other (please specify)
Surgeries
Significant trauma (auto accidents, falls, etc.) and dates
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.)		
Occupationnel 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 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 per week?
Please describe any use of drugs for non-medical purposes	

Please indicate any painful or distressed areas by circling the area



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
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Chang in hair or skin texture
- ☐ Any other hair or skin problems?

Head, eyes, ears nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth 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 throat
- ☐ Sores on lips and tongue
- ☐ Headaches (Where, When?)
- ☐ Any other head or neck problems?

Cardiovascular

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

Respiratory

☐ Cough ☐ Asthma ☐ Shortness of breath

☐ Coughing blood ☐ Difficulty breathing ☐ Pain with a deep breath

☐ Bronchitis ☐ Wheezing while breathing

☐ Pneumonia ☐ Difficulty in breathing when lying down

☐ Production of phlegm, what color?

☐ Any other lung/breathing problems?

Gastrointestinal

☐ Nausea ☐ Diarrhea ☐ Abdominal pain or cramps

☐ Vomiting ☐ Constipation ☐ Rectal pain

☐ Indigestion ☐ Blood in stools ☐ Hemorrhoids

☐ Gas ☐ Black stools ☐ Bad breath

☐ Belching ☐ Chronic laxative use ☐ Bleeding gums

☐ Any other problems with your stomach or intestines?

Urinary

☐ Frequent urination ☐ Pain upon urination ☐ Kidney stones

☐ Urgency to urinate ☐ Blood in urine ☐ Any color in your urine

☐ Unable to hold urine ☐ Decrease in flow

☐ Do you wake up to urine? How often?

☐ Any other problems with your urinary system?

Male Reproductive

☐ Impotence ☐ Premature Ejaculation ☐ Testicular pain/injury

☐ Prostatitis ☐ Spermatorrhea ☐ Testicular cancer

☐ Prostate cancer ☐ Low sperm count ☐ Sores on genitals

☐ Benign prostatic hypertrophy ☐ Low motility ☐ STDs

☐ Any other reproductive problems?

Female Reproductive

Are you pregnant? ☐ *Yes* ☐ *No*

☐ Age of first menses: ☐ Pregnancies #: ☐ Menopause age:

☐ Duration of menses: ☐ Live births #: ☐ Last PAP

☐ Time between menses: ☐ Premature births # ☐ Vaginal discharge

☐ Irregular periods ☐ Miscarriages # ☐ Breast lumps

☐ Painful periods ☐ Abortions # ☐ Sores on genitals

☐ Unusual character (heavy/light ☐ Infertility ☐ STDs

☐ Clots ☐ Western fertility treatment

☐ 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 ☐ Hand/wrist pains ☐ Foot/ankle pains

☐ Shoulder pain ☐ Hip pain ☐ Muscle pain

☐ Back pain ☐ Knee pain ☐ Muscle weakness

☐ Any other muscle, joint or bone problems?

Neurological

☐ Seizures ☐ Dizziness ☐ Areas of numbness

☐ Stroke ☐ Loss of balance ☐ Poor memory

☐ Concussion ☐ Lack of coordination ☐ Tremors (Where?)

☐ Any other neurological problems?

Psychological

☐ Depression ☐ Easily angered ☐ Sadness

☐ Anxiety ☐ Easily susceptible to stress ☐ Overly joyful

☐ Fearful ☐ Easily over worried

☐ Have you ever been treated for emotional problems?

☐ Have you ever considered or attempted suicide?

☐ Any other psychological problems?