

Health History Questionnaire

Date: _____

Last Name: _____ First Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth : _____ Age: _____ Height: _____ Weight: _____

Marital Status: _____ Occupation: _____

Physician: _____ Referred by: _____

Emergency Contact & Tel. # : _____

Have you been treated by Acupuncture or Oriental Medicine in the past? _____

What is the main problem that you are hoping Acupuncture can help you with?

When did these problems begin? Please be specific.

How do these problems interfere with your daily life?

Have you been given a Western Medical diagnosis ? Please specify:

What kinds of treatments have you sought or tried?

Past Medical & Surgical History

Surgeries and Dates: _____

Accidents / Trauma and Dates : _____

Allergic to any drugs, chemicals, foods, environment? _____

If allergic to plants, pollen, etc., what months are you most affected? _____

Please circle all which apply to you:

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Thyroid Disease
Seizures/Epilepsy HIV/ AIDS Hemophilia Sexually Transmitted Disease
Herpes Type 1 or 2 Asthma Emphysema Other: _____

Medicines currently taken or taken within the last 2 months:

Do you exercise regularly? If yes, please describe routine: _____

Diet Please give a detailed description of your average daily:

Breakfast: _____

Lunch : _____

Dinner : _____

Snacks: _____

Coffee or tea intake per day: _____ Caffeinated sodas per day: _____

Do you smoke? _____ How many packs per day? _____

Alcohol intake per day: _____ Alcohol intake per week : _____

Recreational drug use (please describe) : _____

Any past history of drug use : _____

Review of Systems

General

___ Sudden weight loss

___ Sweating

___ Night Sweats

___ Sudden weight gain

___ Peculiar tastes or smells

___ Fevers

___ Insomnia

___ Strong thirst

___ Fatigue

___ Sudden energy drop

___ Cravings

___ Bruising/Bleeding
easily

___ Change in appetite

Skin and Hair

___ Rashes

___ Itching

___ Dandruff

___ Ulcerations

___ Eczema

___ Hair loss

___ Hives
___ Other:

___ Acne/Pimples

___ New moles

Head, Eyes, Ears, Nose, Throat

___ Dizziness
___ Ringing in ears
___ Facial pain
___ Night Blindness
___ Spots in vision
___ Other:

___ Headaches
___ Teeth grinding
___ Facial paralysis
___ Frequent nose bleeds
___ Mouth/throat ulcers

___ Migraines
___ Jaw clicks
___ Dental problems
___ Blurry vision
___ Ear pain

Cardiovascular

___ High blood pressure
___ Irregular heartbeat
___ Cold hands / feet
Other:

___ Low blood pressure
___ Shortness of breath
___ Swelling of hands/feet

___ Chest pain
___ Fainting spells
___ Palpitations

Respiratory

___ Cough
___ Bronchitis
___ Blood in sputum
Other:

___ Difficulty breathing when supine
___ Sleep Apnea
___ Pain with deep breathing

___ Asthma
___ Phlegm

Gastrointestinal

___ Nausea
___ Gas
___ Acid Reflux
___ Abdominal pain/cramps
___ BM Urgency
___ Black stool
Other:

___ Vomiting
___ Belching
___ Bloating
___ Blood in stool
___ Constipation

___ Diarrhea
___ Indigestion
___ Hemorrhoids
___ Loose stools
___ Use of Laxatives

Genitourinary

___ Pain on urination
___ Urgency to urinate
___ Wake at night to urinate
Frequency? _____
Other:

___ Frequent urination
___ Unable to hold urine
___ Impotence

___ Blood in urine
___ Sores on genitals

OB / Gyn

Age of first menses: _____
Number of pregnancies: _____
Number of live births: _____

Number of days between periods: _____
Number of miscarriages / Abortions _____

- Painful periods
- Irregular periods
- Changes in body / moods before menstruation
- Clots
- Vaginal discharge

Please explain: _____

Type of Birth Control: _____
How long? _____

Menopause
Year of onset: _____
Current symptoms (if applicable): _____
Year of completion: _____

Psychological

- Depression
- Panic Attacks
- Mood Swings
- Irrational fears or Phobias
- Decrease Sex drive
- Easily angers
- Poor attention span
- Hallucinations (visual, auditory or tactile)
- Suicide attempts
- Anxiety
- Restlessness

Other: _____

Comments: (Please list any other problems you would like to discuss.)

