Health History Questionnaire

Please take time to completely fill out this questionnaire. It will help me immensely in providing you with a careful evaluation of your health. If you have any questions, please feel free to ask.

All of your answers are confidential.

Date: _____ Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email Address: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Physician: _____ Phone: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Have you ever been treated by Oriental medicine before? ❑ Yes ❑ No

Main Complaint (including symptoms, diagnosis, duration, etc.):

_____

_____

Significant Trauma (physical and/or emotional):

_____

Surgeries (include date of procedure):

_____

Allergies (environmental, drug, food, or chemical):

_____

Medications (include names and dosages):

_____

Vitamins/Supplements/Herbs:

_____

Diet

Meals per Day _____ Snacks _____ Caffeinated Beverages ___ Alcohol per Week _____
How much water do you drink per day? _____
Are you currently on a restricted diet? ❑ Yes ❑ No If so, please describe it: _____

_____

Do you smoke? ❑ Yes ❑ No If so, how many cigarettes per day? _____

Exercise

No. of Days per Week _____ Length of Workout _____ Type of Activity _____

Personal Medical History

Please check any current conditions or symptoms.

❑ Arthritis	❑ High/Low Blood Pressure	❑ Diabetes	❑ Cancer
❑ Heart Disease	❑ Hepatitis	❑ Tuberculosis	❑ Seizures
❑ Thyroid Disease	❑ Asthma	❑ Stroke	❑ Ulcer
❑ Alcoholism	❑ Chemical Dependency	❑ Hypo/Hyperglycemia	❑ Anemia
❑ Lyme Disease	❑ Chronic Pain Condition	❑ Infertility	❑ High Cholesterol
❑ IBS/Diverticulitis	❑ Crohn's Disease	❑ Raynaud's Disease	❑ Carpal Tunnel Syndrome
❑ Impotence	❑ Emphysema	❑ Allergies	❑ Acid Reflux Disease

Family Medical History

Please check any condition that applies to your immediate family. Write "F" for father, "M" for mother, "S" for sister, "B" for brother, "GM" for grandmother, and "GF" for grandfather next to the box you checked.

❑ Diabetes _____	❑ Cancer _____	❑ High Blood Pressure _____
❑ Heart Disease _____	❑ Stroke _____	❑ Seizures _____
❑ Allergies _____	❑ Asthma _____	❑ Other: _____

Please check off any of these items if you have had them in the last 3 months.

General

- ❑ Fevers
- ❑ Night Sweats
- ❑ Sweats Easily
- ❑ Chills
- ❑ Poor Appetite
- ❑ Poor Sleep
- ❑ Sudden Energy Drop
- ❑ Cravings
- ❑ Peculiar Tastes/Smells
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Strong Thirst
- ❑ Bleed/Bruise Easily
- ❑ Muscle weakness/fatigue
- ❑ Poor Balance
- ❑ Tremors

Skin and Hair

- ❑ Rashes
- ❑ Ulcerations
- ❑ Hives
- ❑ Shingles
- ❑ Allergic Dermatitis
- ❑ Eczema/Psoriasis
- ❑ Acne
- ❑ Itching
- ❑ Dandruff
- ❑ Warts
- ❑ Loss of Hair
- ❑ Recent Moles
- ❑ Change in skin/hair texture
- ❑ Dermatitis
- ❑ Fungal Infection

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Concussions
- ❑ Migraines
- ❑ Glasses
- ❑ Eye Strain
- ❑ Poor Vision
- ❑ Eye Pain
- ❑ Night Blindness
- ❑ Color Blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Blurred Vision
- ❑ Spots in Front of Eyes
- ❑ Earaches
- ❑ Ringing in Ears
- ❑ Poor Hearing
- ❑ Sinus Problems
- ❑ Nose Bleeds
- ❑ Recurrent Sore Throats
- ❑ Grinding Teeth
- ❑ Clenching Jaw
- ❑ Facial Pain
- ❑ Sores on Mouth/Lips
- ❑ Dental Problems
- ❑ Jaw Clicks
- ❑ Headaches
- ❑ Difficulty Swallowing

Any other head or neck problems? _____

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Vasovagal
- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Swelling of Feet
- ❑ Blood Clots
- ❑ Phlebitis
- ❑ Varicose/Spider Veins
- ❑ Pressure in Chest
- ❑ Spontaneous Sweating
- ❑ Pacemaker
- ❑ Heart Valve Replacement
- ❑ Bypass Surgery

Respiratory

- ❑ Cough
- ❑ Wheezing
- ❑ Coughing Blood
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Pain Upon Inhalation
- ❑ Tightness in Chest
- ❑ Difficult Inhale/Exhale
- ❑ Difficulty breathing when lying down
- ❑ Cystic Fibrosis
- ❑ Production of Phlegm. What color? _____

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Black Stools
- ❑ Blood in Stools
- ❑ Indigestion
- ❑ Bad Breath
- ❑ Acid Reflux/GERD
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Abdominal Pain/Cramps
- ❑ Chronic Laxative Use
- ❑ Change in Appetite
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Significant Thirst
- ❑ IBS
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Hernia

Genitourinary

❑ Pain Upon Urination ❑ Difficulty Urinating ❑ Frequent Urination ❑ Blood in Urine
❑ Urinary Tract Infection ❑ Urgency to Urinate ❑ Unable to Hold Urine ❑ Kidney Stones
❑ Scanty Urine ❑ Copious Urine ❑ Burning Urination ❑ Impotence
❑ Sores on Genitals ❑ Premature Ejaculation ❑ Low Libido ❑ Prostatitis
❑ Dribbling After Urination ❑ Nocturnal Emissions ❑ Testicular Pain ❑ Herpes
❑ Infections ❑ Nighttime Urination. How often per night? _____

Gynecological

❑ Age at First Period _____ ❑ Duration of Bleeding During Period _____ ❑ Cycle Length _____
❑ Date of Last Period _____ ❑ Color of Blood: _____
❑ Date of Last PAP _____ ❑ Clots Size of Clots: _____
❑ Number of Pregnancies _____ ❑ Vaginal Discharge Color? _____
❑ Number of Live Births _____ ❑ Vaginal Sores
❑ Number of Ectopic Pregnancies _____ ❑ Vaginal Dryness
❑ Number of Miscarriages _____ ❑ Difficult/Painful Intercourse
❑ Number of Abortions _____ ❑ Infertility
❑ PMS ❑ Breast Tenderness ❑ Fibrocystic Breast Tissue ❑ Polycystic Ovarian Disease
❑ Painful Menstruation ❑ Irregular Menstruation ❑ Breast Lumps ❑ Fibroids
❑ Endometriosis ❑ Menopause Age: _____
Do you practice birth control? If so, what kind and for how long have you used this method?

_____

Could you currently be pregnant? ❑ Yes ❑ No
Are you currently pregnant? ❑ Yes ❑ No If Yes, how many weeks? _____

Musculoskeletal

❑ Neck Pain ❑ Back Pain ❑ Shoulder Pain ❑ Hip Pain
❑ Muscle Pain ❑ Muscle Tightness ❑ Muscle Weakness ❑ Sciatica
❑ Spinal Stenosis ❑ Sprains/Strains ❑ Tendonitis ❑ Bursitis
❑ Hand/Wrist Pain ❑ Osteoporosis ❑ Foot/Ankle Pain ❑ Knee Pain

Neuropsychological

❑ Seizures ❑ Dizziness ❑ Loss of Balance ❑ Areas of Numbness
❑ Lack of Coordination ❑ Poor Memory ❑ Concussion ❑ Depression
❑ Anxiety ❑ Panic Attacks ❑ Irritability ❑ Easily Susceptible to Stress
❑ Bipolar Disorder ❑ ADD/ADHD ❑ PTSD ❑ Anorexia
❑ Bulimia ❑ Obsessive Compulsive Disorder

Have you ever been treated for emotional issues? ❑ Yes ❑ No
Have you ever considered or attempted suicide? ❑ Yes ❑ No
Have you ever been treated for substance abuse or other addictions? ❑ Yes ❑ No
Are you currently under the care of a mental health professional? ❑ Yes ❑ No

Comments Please inform me of any other problems or issues you would like to discuss.