

### Health History Questionnaire

Please help us provide you with a complete evaluation by taking 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 on the "Comments" section. Thank you.

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

NAME: \_\_\_\_\_  
FIRST LAST

EMAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ STREET CITY STATE ZIP  
AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ FAMILY PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_ ID: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ PHONE (Ins.): \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_  
NAME PHONE NUMBER

RELATION TO YOU: \_\_\_\_\_

HAVE YOU TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE?  
(CHECK ONE) YES\_\_\_ NO\_\_\_

MAIN PROBLEM(S) YOU WOULD LIKE US TO HELP YOU WITH:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO WHAT EXTENT DOES THIS PROBLEM INTERFERE WITH YOUR DAILY ACTIVITIES SUCH AS WORK, SLEEP, AND SEX?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU BEEN GIVEN A DIAGNOSIS FOR THIS PROBLEM? IF SO, WHAT IS IT?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT OTHER KINDS OF TREATMENTS HAVE YOU TRIED?  
\_\_\_\_\_  
\_\_\_\_\_

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**Past Medical History: (Please include date)**

**SIGNIFICANT ILLNESS** (please circle all applicable)

CANCER  
DIABETES  
HEPATITIS  
HIGH BLOOD PRESSURE  
HEART DISEASE  
RHEUMATIC FEVER

THYROID DISEASE  
SEIZURES  
VENEREAL DISEASE  
OTHER (PLEASE SPECIFY)  
\_\_\_\_\_

**SURGERIES:** \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

**SIGNIFICANT TRAUMA** (AUTO ACCIDENTS, FALLS, ETC): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY** (PLEASE CHECK ALL APPLICABLE):

ASTHMA  
ALLERGIES  
DIABETES  
CANCER  
HEART DISEASE  
HIGH BLOOD PRESSURE

STROKE  
SEIZURE  
THYROID  
OTHER (PLEASE SPECIFY): \_\_\_\_\_

**MEDICINES TAKEN WITHIN THE LAST TWO MONTHS** (VITAMINS, DRUGS, HERBS, ETC.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OCCUPATIONAL 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?

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DO YOU CRAVE CERTAIN FOOD?

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DO CERTAIN FOOD "DISAGREE" WITH YOU?

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PLEASE DESCRIBE YOUR AVERAGE DAILY FOOD INTAKE:

MORNING: \_\_\_\_\_

AFTERNOON: \_\_\_\_\_

EVENING: \_\_\_\_\_

DO YOU SMOKE? IF YES HOW MUCH?

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HOW MUCH CAFFEINATED COFFEE, TEA, OR COLA DO YOU DRINK PER WEEK?

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HOW MUCH WATER DO YOU DRINK DAILY? \_\_\_\_\_

HOW MUCH ALCOHOL DO YOU DRINK? \_\_\_\_\_

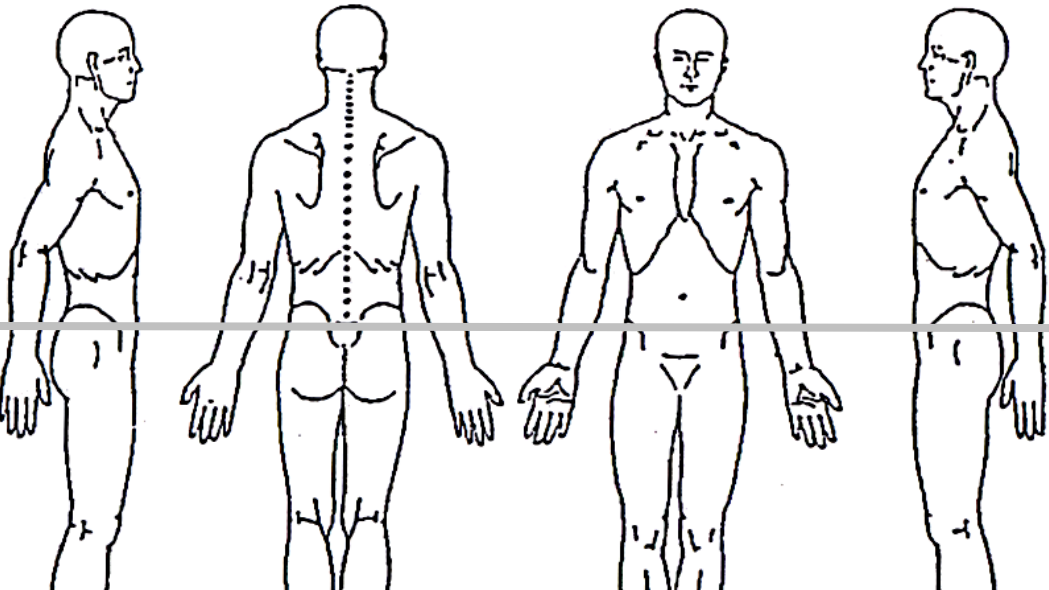
PLEASE DESCRIBE ANY USE OF DRUGS FOR NON-MEDICAL PURPOSES:

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PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS BY CIRCLING THE AREA:

CHECK HAVE THE THREE



PLEASE ALL YOU HAD IN LAST MONTHS: GENERAL

FEVER SWEAT

BRUISE

The diagram consists of four human figures used for marking areas of pain or distress. From left to right: a profile view of a human torso and legs, a back view showing the spine and shoulder blades, a front view showing the chest and abdomen, and another profile view. A horizontal line is drawn across the waist area of all figures. To the left of the first figure, the text 'CHECK HAVE THE THREE' is written vertically. Below the first figure, the words 'FEVER' and 'SWEAT' are written. To the right of the fourth figure, the text 'PLEASE ALL YOU HAD IN LAST MONTHS: GENERAL' is written vertically. Below the fourth figure, the word 'BRUISE' is written.

PECULIER TASTES OR  
SMELLS  
CRAVINGS  
CHANGE IN APPETITE  
WEIGHTLOSS

WEIGHT GAIN  
STRONG THIRST (HOT  
OR COLD DRINKS)  
POOR SLEEP  
FATIGUE

SUDDEN ENGERY DROP  
(TIME OF DAY?)

**SKIN & HAIR**

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RASHES  
ITCHING  
DANDRUFF  
CHANGE IN HAIR OR  
SKIN TEXTURE

ULCERATIONS  
ECZEMA  
LOSS OF HAIR  
HIVES  
PIMPLES

RECENT MOLES  
ANY OTHER HAIR OR  
SKIN PROBLEM

**HEAD, EYES, EARS, NOSE, AND THROAT**

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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  
THROATS  
SORES ON LIPS OR  
TONGUE  
HEADACHES (WHERE,  
WHEN?)  
ANY OTHER HEAD OR  
NECK PROBLEMS?

**CARDIOVASCULAR**

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CHEST PAIN  
IRREGULAR HEARTBEAT  
HIGH BLOOD PRESSURE  
LOW BLOOD PRESSURE  
FAINTING

COLD HAND OR FEET  
SWELLING OF FEET  
SWELLING OF HANDS  
BLOOD CLOTS  
PHLEBITIS

PERIPHERAL ARTERIAL  
SCLEROSIS  
VARICOSE VEINS

**RESPIRATORY**

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COUGH  
COUGHING BLOOD  
BRONCHITIS  
PNEUMONIA  
PRODUCTION OF  
PHLEGM (WHAT COLOR)

ASTHMA  
DIFFICULTY BREATHING  
WHEEZING WHILE  
BREATHING  
DIFFICULTY BREATHING  
WHEN LYING DOWN

SHORTNESS OF BREATH  
PAIN WITH A DEEP  
BREATH  
ANY OTHER LUNG/  
BREATHING PROBLEMS?

**GASTROINTESTINAL**

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NAUSEA  
VOMITTING  
INDIGESTION

GAS  
BELCHING  
DIARRHEA

CONSTIPATION  
BLOOD IN STOOLS  
BLACK STOOLS

CHRONIC LAXATIVE USE  
 ABDOMINAL PAIN OR  
 CRAMPS  
 RECTAL PAIN  
 HEMORRHOIDS

BAD BREATH  
 BLEEDING GUMS  
 ANY OTHER PROBLEMS  
 WITH STOMACH OR  
 INTESTINES?

**URINARY**

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FREQUENT URINATION  
 URGENCY TO URINATE  
 UNABLE TO HOLD URINE  
 PAIN UPON URINATION  
 BLOOD IN URINE

DECREASE IN FLOW  
 KIDNEY STONES  
 ANY PARTICULAR COLOR  
 OF URINE:

DO YOU WAKE UP TO  
 URINATE? HOW OFTEN?  
 ANY OTHER PROBLEMS  
 WITH YOUR URINARY  
 SYSTEM?

**MALE REPRODUCTIVE:**

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IMPOTENCE  
 PROSTATITIS  
 PROSTATE CANCER  
 BENIGN PROSTATIC  
 HYPERTROPHY  
 PREMATURE  
 EJACULATION

SPERMATORRHEA  
 LOW SPERM COUNT  
 LOW MOTILITY  
 TESTICULAR PAIN/  
 INJURY  
 TESTICULAR CANCER  
 SORES ON GENITALS

STD'S  
 ANY OTHER  
 REPRODUCTIVE  
 PROBLEMS?

**FEMALE REPRODUCTIVE:**

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AGE OF FIRST MENSES: \_\_\_\_\_  
 REGULAR MENSTRUAL CYCLE  
 IRREGULAR MENSTRUAL CYCLE  
 MENSTRUAL CYCLE RANGE: \_\_\_\_\_  
 PAINFUL PERIODS  
 UNUSUAL CHARACTER (HEAVY/LIGHT)  
 CLOTS  
 PMS SYMPTOMS: \_\_\_\_\_  
 BIRTH CONTROL/DURATION OF USE  
 \_\_\_\_\_  
 LAST MENSTRUAL PERIOD DATE  
 \_\_\_\_\_

CURRENTLY PREGNANT  
 PREGNANCIES #: \_\_\_\_\_  
 LIVE BIRTHS #: \_\_\_\_\_  
 MISCARRIAGE #: \_\_\_\_\_  
 ABORTION #: \_\_\_\_\_  
 MENOPAUSE AGE: \_\_\_\_\_  
 UNUSUAL VAGINAL DISCHARGE  
 BREAST LUMPS  
 STDs  
 ANY OTHER REPRODUCTIVE PROBLEMS?

**MUSCULOSKELETAL**

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NECK PAIN  
 SHOULDER PAIN  
 BACK PAIN  
 HAND/WRIST PAIN  
 HIP PAIN

KNEE PAIN  
 FOOT/ANKLE PAIN  
 MUSCLE PAIN  
 MUSCLE WEAKNESS

ANY OTHER MUSCLE,  
 JOINT OR BONE  
 PROBLEMS?

**NEUROLOGICAL**

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SEIZURES

STROKE

CONCUSSION

DIZZINESS  
LOSS OF BALANCE

LACK OF COORDINATION  
AREAS OF NUMBESS

POOR MEMORY  
TREMORS (WHERE?)

**PSYCHOLOGICAL**

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DEPRESSION  
ANXIETY  
FEARFUL  
EASILY ANGERED  
EASILY SUSCEPTIBLE TO  
STRESS  
EASILY OVER WORRIED

SADNESS  
OVERLY JOYFUL  
ANY OTHER  
NEUROLOGICAL OR  
PSYCHOLOGICAL  
PROBLEMS?

HAVE YOU EVER BEEN TREATED FOR EMOTIONAL PROBLEMS?

\_\_\_\_\_

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HAVE YOU EVER CONSIDERED OR STTEMPTED SUICIDE?

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**COMMENTS:**

PLEASE BRIEFLY TELL US OF ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS.

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END OF QUESTIONAIRE