Health History Questionnaire Date: _____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This document is part of your confidential medical record. If anything is unclear, please ask. Thoughtful consideration of your answers will help me better address your unique health makeup.

Name (First & Last)	Home Phone	Work Phone
Street Address	City	State/Zip

Date of Birth	Age	Height	Weight	Marital Status

Occupation	Emergency Contact with phone number
Family Physcian	Physician Phone number
How did you hear about us?	

Have you been treated by acupuncture or Chinese herbal medicine before? Yes No
Main problem(s) you would like help with:
How long ago did this problem begin? Please be specific:
Have you been given a diagnosis for this problem? If so, what?
How much does this problem interfere with daily actvities like work, sleep, recreation,etc.?
What kinds of treatment have you tried?

Past medical history '*Circle all that are applicable and please include dates:*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease H.I.V.

Other (Please list)

Surgeries, hospitalizations, significant trauma (auto accidents, falls, etc.)? Please include dates.

Allergies (drugs, chemicals, foods)

Family Medical History

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Other:

Medicines, herbs and vitamins taken in past 2 months (please include dose if applicable):
Do you have a regular exercise program? If yes, please describe:
Have you ever been on a restricted diet? If yes, what kind? Why?
Do you smoke? If yes, how much and how long?
How many caffeinated beverages do you drink per week?
How much water do you drink per day? How much alcohol do you drink?

Please circle if you have had any of the following in the past 3 months:

General:

Fevers	Poor sleeping	Fatigue
Sweat easily	Chills	Night Sweats
Bleed or bruise easily	Strong thirst (hot or cold drinks?)	Cravings
Peculiar tastes or smells	Weight loss	Change in appetite
Sudden energy drop	Weight gain	

Skin and Hair:

Rashes	Ulcerations	Hives
Itching	Eczema	Pimples
Dandruff	Loss of hair	Recent moles
Change in hair or skin texture	Any other hair or skin problems?	

Head, Neck, Eyes, Ears, Nose, and Throat:

Dizziness	Concussions	Migraine
Glasses/Contact lenses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes/floaters
Sinus problems	Nose bleeds	Recurrent sore throats
Grinding teeth	Facial pain	Sores on lips or tongue
Teeth problems	Jaw clicks	Headaches (where? when?)
Any other head or neck problems?		

Cardiovascular:

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Difficulty in breathing	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Blood clots	Pacemaker (date implanted)	

Any other Heart conditions?

Respiratory:

Coughing	Coughing blood	Asthma
Bronchitis	Pneumonia	Pain with breathing
Difficulty inhaling/exhaling	Production of phlegm What color?	

Any other lung problems?

Gastrointestinal:

Nausea	Vomiting	Diarrhea
Constipation	Gas	Belching
Black stools	Blood in stools	Indigestion
Bad breath	Rectal pain	Hemorrhoids
Abdominal pain or cramps	Chronic laxative use	Bloating

Any other problems with your stomach or intestines?

Genito-Urinary:

Pain when urinating	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Decrease in urine flow	Impotence	Sores on genitals
Strong odor to urine	Cloudy urine	
Do you wake up to urinate? How often?	Any particular color to your urine?	

Any other problems with your genital or urinary system?

OB/GYN

# of Pregnancies_____	# of Live births_____	# of Miscarriages_____
# of Abortions_____	# of Premature births_____	Age of first menses_____
Date of Last PAP smear_____	Duration of menses_____	Length of cycle_____
Irregular periods	Painful periods	Heavy or Light flow?
Period between menses	Vaginal discharge	Clots in menses
Breast lumps	Age of menopause onset_____	Vaginal sores

Changes in body/psyche prior to menstruation

Are you currently pregnant? Yes No Are you trying to get pregnant? Yes No
Do you practice birth control? What type and for how long?

Musculoskeletal:

Neck pain	Muscle pain	Knee pain
Back pain: Upper? Lower?	Muscle weakness	Foot/ankle pains
Hand/wrist pain	Shoulder pain	Hip pain

Any other joint or bone problems?

Neuropsychological:

Seizures	Dizziness	Loss of balance
Areas of numbness	Lack of coordination	Poor memory
Concussion	Depression	Anxiety
Bad temper	Easily susceptible to stress	

Have you ever been treated for emotional problems? Please list:

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Please describe any other issues you would like to discuss: