

**HEALTH HISTORY QUESTIONNAIRE**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: \_\_\_\_\_

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 (be specific)?

\_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex)?

\_\_\_\_\_

Have you been given a diagnosis for this problem?

\_\_\_\_\_

What kinds of treatment have you tried?

\_\_\_\_\_

**Past Medical History** (please include dates):

**Significant Illnesses:**

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Hepatitis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Seizures \_\_\_\_\_ Heart Disease \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ STDs \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

**Surgeries:**

\_\_\_\_\_

**Significant Trauma** (auto accidents, falls, etc.):

\_\_\_\_\_

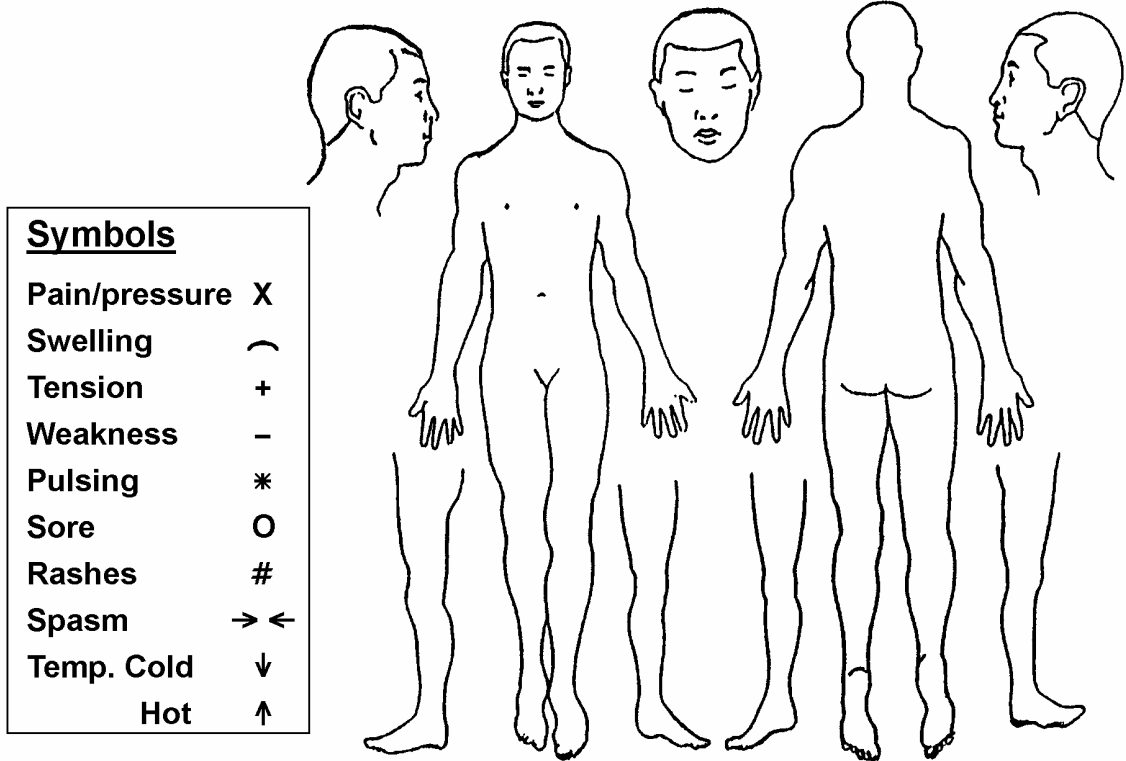
**Birth History:** (prolonged labor, forceps delivery, etc.):

Allergies (drugs, chemicals, foods):

Family History: Diabetes Cancer High Blood Pressure Heart Disease  
Strokes Seizures Asthma Allergies Other

Medications taken within the last two months (including drugs, vitamins and herbs, etc.):

Indicate painful or distressed areas:



Do you have a regular exercise program? \_\_\_\_\_ Please describe: \_\_\_\_\_

Are you on a restricted diet? \_\_\_\_\_ What kind? \_\_\_\_\_

Please describe your typical daily diet:  
Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs of cigarettes do you smoke a day? \_\_\_\_\_

How much coffee, tea, or cola do you drink per week? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

Do you use any recreational drugs? \_\_\_\_\_

**Please check if you have had** (in the last three months):

**General**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor Appetite                          | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue            |
| <input type="checkbox"/> Fevers                                 | <input type="checkbox"/> Chills        | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Sweat Easily                           | <input type="checkbox"/> Tremors       | <input type="checkbox"/> Cravings           |
| <input type="checkbox"/> Localized Weakness                     | <input type="checkbox"/> Poor Balance  | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Bleed or Bruise Easily                 | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Weight Gain        |
| <input type="checkbox"/> Peculiar Tastes or Smells              |  |   |
| <input type="checkbox"/> Strong Thirst (cold or hot drinks)     |  |   |
| <input type="checkbox"/> Sudden Energy Drop (What time of day)? |  |   |

**Skin and Hair**

- |   |                                       |                                       |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes                         | <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Itching                        | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Pimples      |
| <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture |                                       |                                       |
| Any hair or skin problems?                              |                                       |                                       |

**Head, Eyes, Ears, Nose, and Throat**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Concussions     | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Eye Pain                |
| <input type="checkbox"/> Poor Vision     | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness         |
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Blurry Vision   | <input type="checkbox"/> Earaches                |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing    | <input type="checkbox"/> Spots in Front of Eyes  |
| <input type="checkbox"/> Sinus Problems  | <input type="checkbox"/> Nose Bleeds     | <input type="checkbox"/> Recurrent Sore Throats  |
| <input type="checkbox"/> Grinding Teeth  | <input type="checkbox"/> Facial Pain     | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems  | <input type="checkbox"/> Jaw clicks      |  |
| Headaches (Where and when?)              |  |  |
| Any other head or neck problems?         |  |  |

**Cardiovascular**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain              |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Fainting                |
| <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Swelling of Hands  | <input type="checkbox"/> Swelling of Feet        |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Phlebitis          | <input type="checkbox"/> Difficulty in Breathing |
| Any other heart or blood vessel problems?    |   |  |

**Respiratory**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough                                   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Bronchitis                              | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Pain With a Deep Breath |
| <input type="checkbox"/> Difficulty in Breathing When Lying Down |   |  |
| <input type="checkbox"/> Production of Phlegm (What color?)      |   |  |
| Any other lung problems?   |   |  |

**Gastrointestinal**

- |                                       |  |                                      |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Diarrhea    |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas             | <input type="checkbox"/> Belching    |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath   | <input type="checkbox"/> Rectal Pain     | <input type="checkbox"/> Hemorrhoids |

 Abdominal Pain or Cramps Chronic Laxative Use

Any other problems with your stomach or intestines?

**Genito-Urinary**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pain When Urinating | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Blood in Urine    |
| <input type="checkbox"/> Urgency to Urinate  | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones     |
| <input type="checkbox"/> Decrease in Flow    | <input type="checkbox"/> Impotency            | <input type="checkbox"/> Sores on Genitals |

Do you wake up to urinate?      How often?

Any particular color of your urine?

Any other problems with your genital or urinary system?

**Pregnancy and Gynecology**

- |                          |                     |                              |
|--------------------------|---------------------|------------------------------|
| __ Number of Pregnancies | __ Number of Births | __ Premature Births          |
| __ Miscarriages          | __ Abortions        | __ Age at First Menses       |
| __ Period Between Menses | __ Duration         | __ First Date of Last Menses |
- Unusual Character (Heavy or Light)
- Painful Periods       Clots
- Vaginal Discharge       Vaginal Sores
- Changes in Body/Psyche Prior to Menstruation
- Irregular periods
- Last PAP
- Breast Lumps

Do you use birth control?

What type and for how long?

**Musculoskeletal**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Muscle Pains    | <input type="checkbox"/> Knee Pain        |
| <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pains |
| <input type="checkbox"/> Hand/Wrist Pains | <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Hip Pain         |

Any other joint or bone problems?

**Neuropsychological**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination         | <input type="checkbox"/> Poor Memory     |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Bad Temper        | <input type="checkbox"/> Easily Susceptible to Stress |  |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

**Comments**

Please tell us of any other problems you would like to discuss:

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