Health History Questionnaire

Name:	Phone:	(H):	(W):
Street:		Age: Ht.:	Wt.:
City:		Birthdate:	Sex:
State: Zip:		Occupation:	
Marital Status:		Employer:	
Physician:			
Main Complaint:			
Other Concurrent Therapies:			

Have you been treated by acupuncture or Chinese medicine before? Yes No
How long ago did your main complaint begin? Please be specific.
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?
What kinds of treatments have you tried?

Past Medical History (Include Date):

Significant Illnesses:

____Cancer ____Diabetes ____High Blood Pressure ____Heart Disease ____Hepatitis

____Rheumatic Fever ____Thyroid Disease ____Seizures ____Other

Surgeries:

Significant Trauma (auto accidents, falls, etc):

Allergies: (drugs, chemicals, foods)

Medicines taken within the last two months (including vitamins, over the counter drugs, herbs, etc.):

Occupational Stresses Chemical, physical, psychological, etc.

Family Medical History:
____Cancer ____Diabetes ____High Blood Pressure ____Heart Disease ____Allergies ____Stroke ____Seizures ____Alcoholism ____ Asthma ____ Other

Routines/Habits:
Do you have a regular exercise program? If yes, please describe.
Have you ever been on a restricted diet? If yes, what kind?
Please describe your average daily diet:
Morning:
Afternoon:
Evening:
How much water do you drink per day?
Do you smoke? If yes, how much?
How much caffinated coffee, tea, or cola do you drink per week?
Please describe any use of drugs for non-medicinal purposes.

Comments:

Name_____ Date _____

Skin and Hair

☐ Rashes	☐ Acne	☐ Ulcerations	☐ Dandruff
☐ Eczema	☐ Hives	☐ Purpura	☐ Loss of hair
☐ Psoriasis	☐ Itching	☐ Change in hair/skin texture	☐ Premature gray hair

Head, Eyes, Ears, Nose and Throat

☐ Dizziness	☐ Eye strain	☐ Dry eyes	☐ Dry throat
☐ Headaches	☐ Eye pain	☐ Ringing in ears	☐ Recurrent sore throat
☐ Migraines	☐ Cataracts	☐ Earaches	☐ Dry mouth
☐ Concussions	☐ Poor vision	☐ Poor hearing	☐ Copious saliva
☐ Facial pain	☐ Blurry vision	☐ Sinus problems	☐ Other
☐ Teeth problems	☐ Floaters in eyes	☐ Nose bleeds	
☐ Grinding teeth	☐ Glasses	☐ Mucous	
☐ Jaw clicks	☐ Night blindness	☐ Gum problems	

Cardiovascular

☐ High Blood Pressure	☐ Low blood pressure	☐ Chest pain	☐ Irregular heartbeat
☐ Dizziness	☐ Fainting	☐ Cold hands/feet	☐ Swelling in hands/feet
☐ Blood clots	☐ Phlebitis	☐ Difficulty breathing	☐ Other

Respiratory

☐ Cough	☐ Coughing Blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Tight chest	☐ Production of phlegm (color?) _____	☐ Other

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Bowel Movement:
☐ Gas	☐ Belching	☐ Black stool	_____Frequency
☐ Bad breath	☐ Rectal pain	☐ Hemorrhoids	_____Color
☐ Constipation	☐ Bloody stool	☐ Sensitive abdomen	_____Odor
☐ Pain or cramps	☐ Laxative use: Frequency:____		_____Texture

Genito-Urinary

☐ Pain on urination	☐ Frequent urination	☐ Blood in urine	☐ Urgency to urinate
☐ Unable to hold urine	☐ Kidney stones	☐ Venereal disease	☐ Impotence
☐ Wake up to urinate ---	How often?_____/night	Time of evening?_____	

Pregnancy and Gynecology

Age at first menses ____	☐ Irregular periods	Pregnancies (#) _____	☐ Vaginal discharge
Menses flow: ____days	☐ Clots	☐ Miscarriages	☐ Vaginal sores
Flow: __heavy __ light	☐ PMS	☐ Premature births	
Date of last menses____	☐ Breast lumps	☐ Menopause	

Musculoskeletal

☐ Neck pain	☐ Muscle pain	☐ Back pain (location?)	☐ Joint pains (location?)
☐ Other joint or bone problems?			

Neuropsychological

☐ Seizures	☐ Areas of numbness	☐ Poor memory	☐ Concussion
☐ Depression	☐ Anxiety	☐ Bad temper	☐ Easily stressed
☐ Emotional problems	☐ Consider/attempted suicide	☐ Other	

General

☐ Poor Appetite	☐ Tremors	☐ Fevers	☐ Cravings
☐ Excess appetite	☐ Vertigo	☐ Chills	☐ Change in appetite
☐ Poor Sleep	☐ Cold Hands	☐ Night Sweats	☐ Daytime energy drop
☐ Excess sleep	☐ Cold Feet	☐ Sweats Easily	☐ Peculiar taste/smell
☐ Insomnia	☐ Cold back	☐ Localized weakness	☐ Strong thirst
☐ Fatigue	☐ Cold abdomen	☐ Poor coordination	☐ Bruise easily