Health History Questionnaire for Patients

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

Name:

Street: City: State: Zip:

Age: Height: Weight:

Home Phone: Work Phone: Email:

Date/Place of Birth: Social Security Number:

Occupation: Marital Status:

In Emergency Notify:

Referred by:

Family Physician:

Insurance Carrier: Policy Number:

Have you tried acupuncture or Chinese herbal medicine before?

What is your main problem?

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

Past Medical History (Please include dates)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps, delivery, etc)
- ☐ Other significant illness (describe)
- ☐ Accidents or significant trauma (describe)

Other Relevant Medical History

Family Medical History

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

Occupation

Occupational stress factors (physical, psychological, chemical): ______

______

Lifestyle

Do you follow a regular exercise program? ______ If so, please describe: ______

______

Please describe your average diet: ______

______

Please check any of the following habits that apply. How much and how often do you use them?

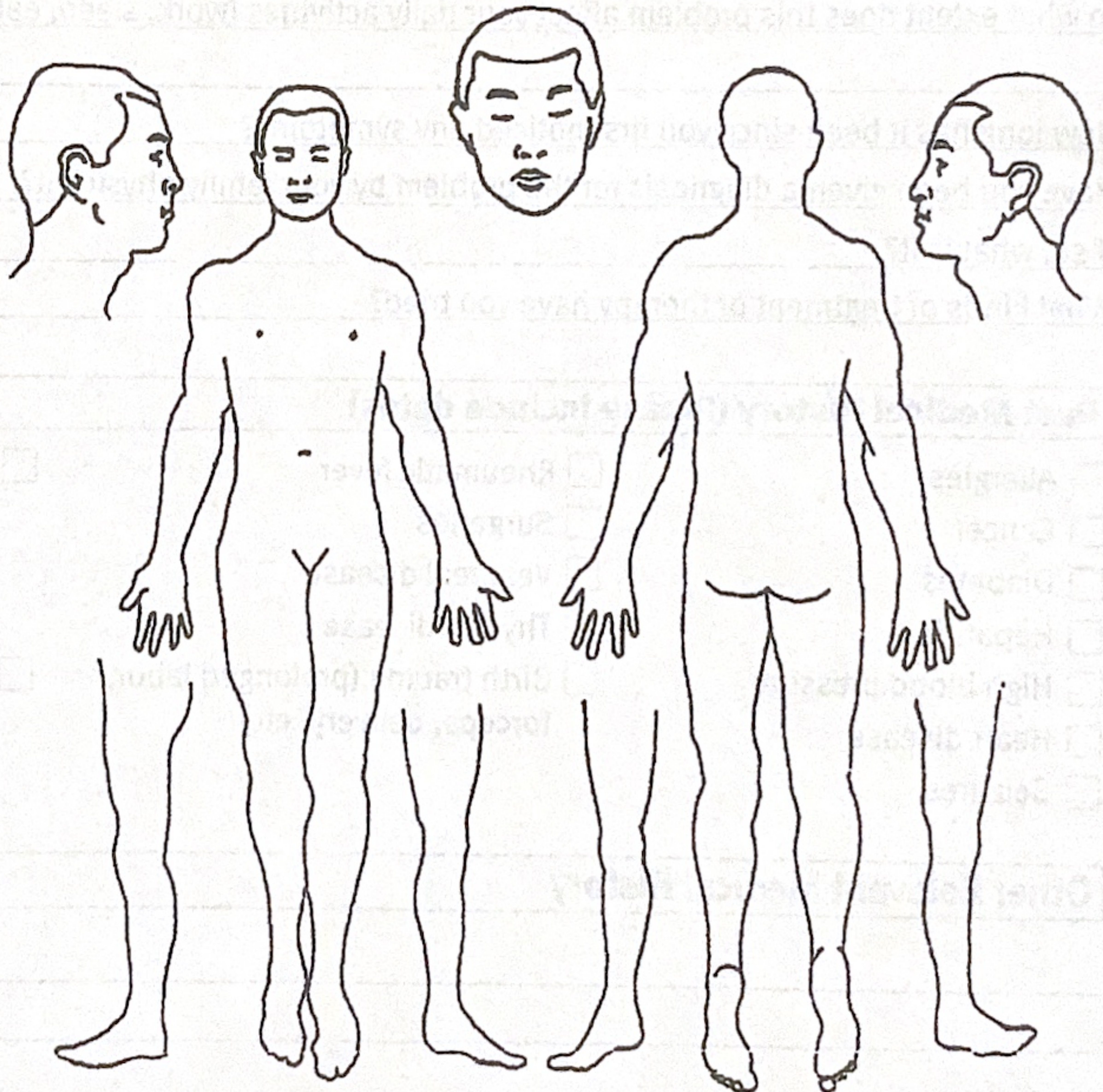
☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.): ______

Please describe any use of drugs for non-medical purposes: ______

SYMBOL	REACTION
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
=	weak
#	tense
Spontaneous pain	
•	slight
••	moderate
•••	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
-	colder
+	hotter
Physical	
N	sores
*	rashes
« »	spasm

Please Mark Painful or Distressed Areas on the Charts Below



Check next to any conditions you have experienced within the last three months. Indicate the length of time you have had this condition.

General

- [ ] Poor appetite
- [ ] Insomnia
- [ ] Disturbed sleep
- [ ] Localized weakness
- [ ] Cravings
- [ ] Strong thirst
- [ ] Weight gain
- [ ] Weight loss
- [ ] Changes in appetite
- [ ] Sweating easily
- [ ] Tremors
- [ ] Bleeding or bruising easily
- [ ] Night sweats
- [ ] Fever
- [ ] Chills
- [ ] Sudden energy drop (time of day?)
- [ ] Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health ____________________

____

Skin and Hair

- [ ] Rashes
- [ ] Ulcerations
- [ ] Hives
- [ ] Itching
- [ ] Eczema
- [ ] Pimples
- [ ] Dandruff
- [ ] Hair loss
- [ ] Recent moles
- [ ] Changes in texture of hair or skin

Any other skin problems? ____________________

Head, Eyes, Ears, Nose, Throat

- [ ] Dizziness
- [ ] Concussions
- [ ] Migraines
- [ ] Glasses
- [ ] Spots in front of eyes
- [ ] Eye pain
- [ ] Poor vision
- [ ] Night blindness
- [ ] Color blindness
- [ ] Cataracts
- [ ] Blurry vision
- [ ] Earaches
- [ ] Ringing in ears
- [ ] Poor hearing
- [ ] Eye strain
- [ ] Sinus problems
- [ ] Recurrent sore throats
- [ ] Nose bleeds
- [ ] Grinding teeth
- [ ] Sores on lips or tongue
- [ ] Facial pain
- [ ] Teeth problems
- [ ] Headaches (where? when?)
- [ ] Jaw clicks

Any other head or neck problems: ____________________

Cardiovascular

- [ ] Dizziness
- [ ] Low blood pressure
- [ ] Chest pain
- [ ] Irregular heartbeat
- [ ] High blood pressure
- [ ] Fainting
- [ ] Cold hands or feet
- [ ] Swelling of hands
- [ ] Swelling of feet
- [ ] Blood clots
- [ ] Difficulty in breathing
- [ ] Phlebitis

Any other heart or blood vessel problems? ____________________

Respiratory

- [ ] Cough
- [ ] Coughing up blood
- [ ] Asthma
- [ ] Bronchitis
- [ ] Pain with deep inhalation
- [ ] Pneumonia
- [ ] Difficulty breathing when lying down
- [ ] Excessive phlegm (color?)

Any other lung problems? ____________________

Gastrointestinal

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

Any other problems with stomach or intestines: ____________________

Genitourinary

- ☐ Pain on urination
- ☐ Urgent or frequent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate? ________ If so, how often? ________

Any particular color to your urine? ____________________

Any other genital or urinary problems? ____________________

Reproductive and Gynecologic

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses: ________ Age at menopause: ________ Number of pregnancies: ________

Time between cycles: ________ Duration of bleeding: ________ First day of last menses: ________

Do you practice birth control? ________ If so, what type? ________ For how long? ________

Any other gynecological problems? ____________________

Musculoskeletal

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pain
- ☐ Hand/wrist pain
- ☐ Shoulder pain
- ☐ Hip pain

Any other joint or bone problems? ____________________

Neuropsychological

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ 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 list any other problems you would like to discuss: ____________________

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