



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

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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)

Cancer \_\_\_\_\_

Seizures \_\_\_\_\_

Diabetes \_\_\_\_\_

Surgeries \_\_\_\_\_

Heart disease \_\_\_\_\_

Thyroid disease \_\_\_\_\_

Hepatitis \_\_\_\_\_

Venereal disease \_\_\_\_\_

High blood pressure \_\_\_\_\_

Birth trauma (prolonged labor, forceps delivery) \_\_\_\_\_

Rheumatic fever \_\_\_\_\_

Allergies: \_\_\_\_\_

Other significant illness (describe) \_\_\_\_\_

Accidents or significant trauma (describe) \_\_\_\_\_

## OTHER RELEVANT MEDICAL HISTORY

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

## FAMILY MEDICAL HISTORY

- Allergies  
 Cancer  
 Seizures

- Diabetes  
 Heart disease  
 Stroke

- Asthma  
 High blood pressure  
 Other

## OCCUPATION

Occupational stress factors (physical, psychological, chemical): \_\_\_\_\_  
 \_\_\_\_\_

## LIFESTYLE

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

Please describe your average daily 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 \_\_\_\_\_

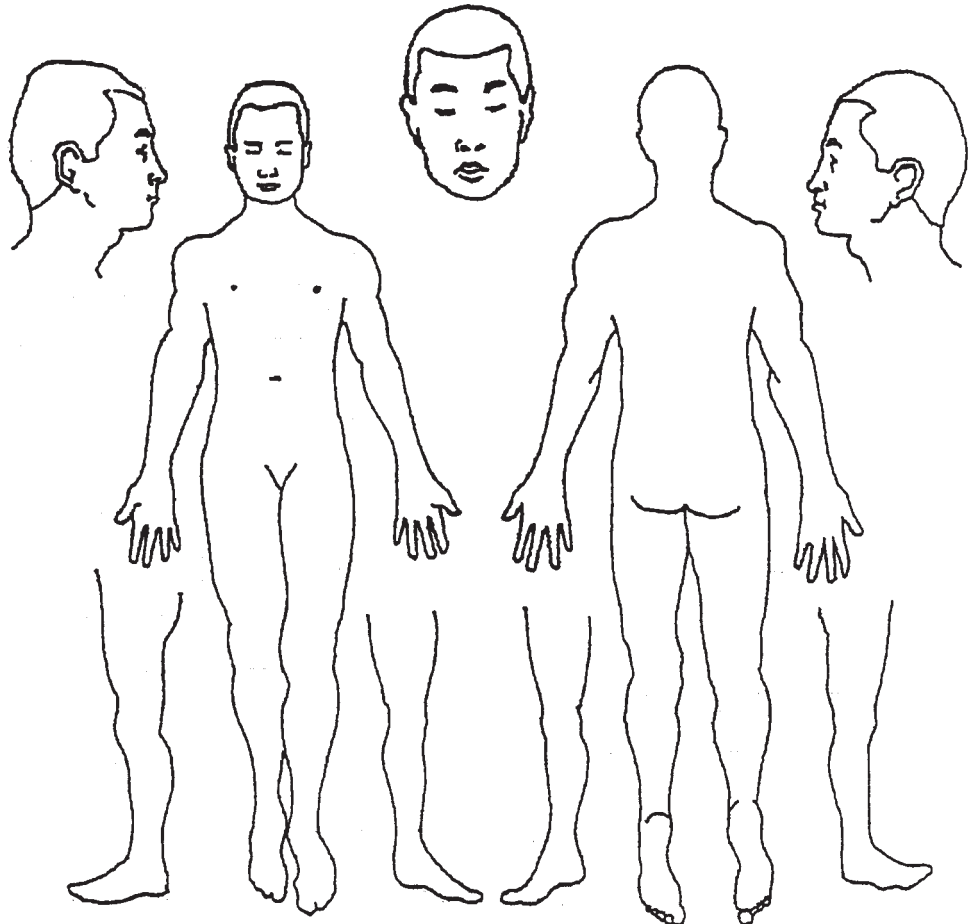
List medications taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_  
 \_\_\_\_\_

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

Please put a

Mark Painful or Distressed Areas on The Charts Below

Symbol	Reaction
<b>Pain on Pressure</b>	
x	little
xx	moderate
xxx	strong
<b>Swelling</b>	
^^^	slight
^^^	moderate
^^^	severe
<b>Tension/Weakness</b>	
=	weak
#	tense
<b>Spontaneous Pain</b>	
+	slight
++	moderate
+++	severe
<b>Pulsing</b>	
o	slight
oo	moderate
ooo	strong
<b>Temperature</b>	
-	colder
+	hotter
<b>Physical</b>	
Ø	sores
*	rashes
<<>>	spasms



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

### GENERAL

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor appetite _____      | <input type="checkbox"/> Weight gain _____                 | <input type="checkbox"/> Night sweats _____                               |
| <input type="checkbox"/> Insomnia _____           | <input type="checkbox"/> Weight loss _____                 | <input type="checkbox"/> Fever _____                                      |
| <input type="checkbox"/> Disturbed sleep _____    | <input type="checkbox"/> Changes in appetite _____         | <input type="checkbox"/> Chills _____                                     |
| <input type="checkbox"/> Localized weakness _____ | <input type="checkbox"/> Sweating easily _____             | <input type="checkbox"/> Sudden energy drop _____<br>(Time of day?) _____ |
| <input type="checkbox"/> Cravings _____           | <input type="checkbox"/> Tremors _____                     | <input type="checkbox"/> Poor balance _____                               |
| <input type="checkbox"/> Strong thirst _____      | <input type="checkbox"/> Bleeding or bruising easily _____ |   |

Other unusual or abnormal conditions you have noticed in your general sense of health. \_\_\_\_\_

### SKIN AND HAIR

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Rashes _____      | <input type="checkbox"/> Eczema _____    | <input type="checkbox"/> Recent moles _____                          |
| <input type="checkbox"/> Ulcerations _____ | <input type="checkbox"/> Pimples _____   | <input type="checkbox"/> Changes in texture of<br>hair or skin _____ |
| <input type="checkbox"/> Hives _____       | <input type="checkbox"/> Dandruff _____  |  |
| <input type="checkbox"/> Itching _____     | <input type="checkbox"/> Hair loss _____ |  |

Any other hair or skin problems. \_\_\_\_\_

### HEAD, EYES, EARS, NOSE, THROAT

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

Any other head or neck problems. \_\_\_\_\_

### CARDIOVASCULAR

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dizziness _____           | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Swelling of feet _____        |
| <input type="checkbox"/> Low blood pressure _____  | <input type="checkbox"/> Fainting _____            | <input type="checkbox"/> Blood clots _____             |
| <input type="checkbox"/> Chest pain _____          | <input type="checkbox"/> Cold hands or feet _____  | <input type="checkbox"/> Difficulty in breathing _____ |
| <input type="checkbox"/> Irregular heartbeat _____ | <input type="checkbox"/> Swelling of hands _____   | <input type="checkbox"/> Phlebitis _____               |

Any other heart or blood vessel problems. \_\_\_\_\_

### RESPIRATORY

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cough _____             | <input type="checkbox"/> Bronchitis _____                | <input type="checkbox"/> Difficulty breathing when<br>lying down _____ |
| <input type="checkbox"/> Coughing up blood _____ | <input type="checkbox"/> Pain with deep inhalation _____ | <input type="checkbox"/> Excessive phlegm (color?) _____               |
| <input type="checkbox"/> Asthma _____            | <input type="checkbox"/> Pneumonia _____                 |  |

Any other lung problems. \_\_\_\_\_

**GASTROINTESTINAL**

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

Any other problems with stomach or intestines? \_\_\_\_\_

**GENITOURINARY**

- Pain on urination \_\_\_\_\_
- Frequent urination \_\_\_\_\_
- Blood in urine \_\_\_\_\_
- Urgency to 'urinate \_\_\_\_\_
- Unable to hold urine \_\_\_\_\_
- Kidney stones \_\_\_\_\_
- Decrease in flow \_\_\_\_\_
- 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 \_\_\_\_\_
- Light menstrual flow \_\_\_\_\_
- Abortions \_\_\_\_\_
- Heavy menstrual flow \_\_\_\_\_
- Miscarriages \_\_\_\_\_
- Unusual menses \_\_\_\_\_
- Premature births \_\_\_\_\_
- Painful menses \_\_\_\_\_
- Other problems \_\_\_\_\_
- Menstrual clots \_\_\_\_\_
- Irregular menses \_\_\_\_\_

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 gynecologic problems? \_\_\_\_\_

**MUSCULOSKELETAL**

- Neck pain \_\_\_\_\_
- Muscle pains \_\_\_\_\_
- Knee pain \_\_\_\_\_
- Back pain \_\_\_\_\_
- Muscle weakness \_\_\_\_\_
- Foot/ankle pains \_\_\_\_\_
- Hand/wrist pains \_\_\_\_\_
- Shoulder pains \_\_\_\_\_
- Hip pain \_\_\_\_\_

Any other joint or bone problems? \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

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

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_