Health History Form

Today's date_____
Name_____ Nickname_____
Phone (H) _____ (W)_____ (C)_____
Address_____
City _____ State _____ Zip _____ E-mail _____
Age _____ Date of Birth _____ Place of Birth_____
Height _____ Weight _____ Marital/Partnership Status _____
Profession_____
Family Physician _____ Referred By _____
Emergency Contact _____ Phone_____

Have You Been Treated By Acupuncture or Oriental Medicine Before? Yes No
Main Problem(s) you would like help with_____
_____
_____
How long ago did this problem begin (be specific)? _____
_____
To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____
_____
Have you been given a diagnosis for this problem: If so, what? _____
_____
What kinds of treatment have you tried? _____
_____

Past Medical History (please include date):
Cancer _____ Diabetes _____ Hepatitis _____
Blood Pressure High/Low _____/_____ Heart Disease _____
Rheumatic Fever_____ Thyroid Disease _____ Seizures _____
STDs_____ HIV/AIDS _____
Other _____

Surgeries (type of and date) _____
_____
Significant Trauma (auto accidents, falls, etc) _____
_____
Significant Dental Work (type and date)_____
Allergies (drugs, chemicals, foods/result) _____
_____

Family Medical History (check): Diabetes Cancer High Blood Pressure

Heart Disease Stroke Seizures Asthma Allergies

Other _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical, chemical, psychological, etc) _____

_____

Do you have a **regular exercise program**? Yes No Please Describe _____

_____

Have you ever been on a **restricted diet**? Yes No What Kind? _____

_____

Are you a smoker? Yes No Quit

If so, how many **packs of cigarettes** do you smoke per day? _____/day

How many caffeinated beverages (**coffee, cola**, **energy drinks**) do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

Please check any problems you have had in the last three months:

General
- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- No desire to drink
- Sudden energy drop
  When? _____
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair
- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems

_____
_____

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

Head, Eyes, Ears, Nose, and Throat
- Dizziness
- Poor vision
- Cataracts
- Eye strain
- Night blindness
- Blurry vision
- Spots in front of eyes
- Eye pain
- Color blindness
- Earaches
- Ringing in ears (tinnitus)
- Poor hearing
- Sinus problems
- Grinding teeth
- Teeth problems
- Jaw clicks
- Facial pain
- Nose bleeds
- Recurrent sore throats
- Sores on lips or tongue
- Concussions
- Migraines
- Headaches - where and when _____
  _____
- Other head or neck problems _____
  _____

Cardiovascular
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Swelling of feet
- Phlebitis
- Chest pain
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____
  _____

Respiratory
- Cough
- Bronchitis
- Pneumonia
- Asthma
- Tuberculosis
- Pain with a deep breath
- Difficulty in breathing when lying down
- Production of phlegm what color _____
- Coughing blood
- Other lung problems _____
  _____
- Approximately when was your last cold or flu?_____
  _____

Gastrointestinal
- Nausea
- Constipation
- Diarrhea
- Chronic laxative use
- Bad breath
- Belching
- Burning sensation
- Abdominal pain or cramps
- Vomiting
- Gas
- Indigestion
- Blood in stools
- Black stools
- Rectal pain
- Rectal burning
- Anal Prolapse
- Hemorrhoids
- Other stomach or intestinal problems _____
  _____

Pregnancy and Gynecology

Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
_____

Unusual character (heavy or light)
Painful periods
Vaginal discharge
What color?_____
Changes in body/psyche prior to menstruation
Clots
Vaginal sores
Irregular periods
Last Pap _____
Breast lumps
Fibroid Cysts
Are you sexually active?__

Do you practice birth control?

Yes No N/A

What type and for how long?
_____

Other Gynecology related concerns_____
_____
_____

Genito-urinary

Pain on urination
Urgency to urinate
Frequent urination
Unable to hold urine
Urinary difficulty
Impotency
Blood in urine
Kidney stones
Sores on genitals
Other genital or urinary system problems _____
_____

Do you wake up to urinate?

Yes No

How often?
_____

Any particular color to your urine? _____

Neuropsychological

Seizures
Stroke
Tremors
Fainting spells
Areas of numbness
Concussion
Poor memory
Dizziness
Vertigo
Loss of balance
Lack of coordination
Depression
Easily stressed
Bad temper
Anxiety
Difficulty concentrating
Other neurological or psychological concerns
_____
_____

Please note the severity of your main problem now:

No Problem Worst Imaginable

Please note the severity of your main problem within the last week:

No Problem Worst Imaginable

Comments (please mention any other problems or concerns you would like to discuss)

_____

_____

_____

_____

Indicate painful or distressed areas