Health History Form

Date _____/ _____/_____

Name: First	Middle	Last	
Address	Street	City/State/Zip code	
Home phone	Work phone	Email address	
Date of Birth	Age	Height	Weight
Family Physician	Phone		
Emergency contact	Emergency contact phone	Relationship	
Referred by:	Have you ever been treated with acupuncture before?		

What is the main problem(s) you would like help with? (include date of onset): _____

_____

_____

Is it getting better or worse? _____

Do you know what caused the problem? _____

Have you been given a diagnosis for this problem? _____

What kind of treatments have you tried? _____

_____

Current/Past Medical History (Please check if you currently have or have had in the past. Include date**)**

- ☐ AIDs/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Tonsillectomy
- ☐ Other (Specify)

_____

_____

Significant Trauma (Physical or emotional—auto accidents, falls, divorce, death in family. Please include date.)

_____

_____

Dental Work (type and date) _____

_____

Describe your typical meal for: Breakfast_____

Lunch_____

Dinner_____

Snacks _____

Health History Form

Hospitalizations and operations / Year

_____
_____
_____
_____
_____
_____

Women – Menstrual history & pregnancies:

Age at first menses:_____
Date of last menses:_____
Length of cycle, start to start (days):_____
Length of flow (days):_____
Current contraception:_____
Age at menopause:_____
Total pregnancies:_____ Live births:_____
Miscarriages: Terminations:

Risk factors: (check all boxes that apply)

Tobacco use:
□ Never
□ Former: year quit_____
□ Current: year started_____
□ Cigarettes: packs per day_____
□ Cigars: number per week_____
□ Smokeless: cans per day_____

Secondhand smoke exposure: □No □Yes

Drug use: □ No □Yes:
list_____
_____

HIV high risk behavior: □ No □ Yes

Caffeine: □No □Yes: drinks/day:_____

Alcohol: □No □Yes: drinks/day:_____

Exercise: type & times per week_____
_____

Seat belt use: (circle)
always usually half the time
sometimes never

Medications & dose: (include prescription, over the counter, vitamins, herbs, etc.)

_____
_____
_____
_____
_____

Allergies: (include reaction) □ None

_____
_____

Family Medical History: (list relative)

Alcoholism: _____
Asthma: _____
Breast cancer: _____
Colon cancer:_____
Depression/suicide: _____
Diabetes: _____
Heart disease: _____
High blood pressure: _____
High cholesterol: _____
Osteoporosis: _____
Ovarian cancer: _____
Prostate cancer: _____
Stroke: _____
Other: _____

Social history:

Marital status: (circle) single married separated divorced widowed live w/partner

History of domestic abuse: □No □Yes
Religion affects healthcare: □No □Yes
Explain: _____
Education completed: (circle)

high school/GED college/tech grad/professional

Occupation: (present or previous) □ Retired
_____
Do you experience occupational stress? (chemical, physical, psychological) _____
_____
Children: (first name and year born)
_____
_____

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Patient Name: _____ Date: _____

Review of Systems: (check any symptoms you are currently experiencing)

General
- ☐ Chills
- ☐ Fever
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (for hot or cold drinks)
- ☐ Fatigue
- ☐ Sudden energy drop
  Time of day? _____
- ☐ Edema Where?
  _____
- ☐ Poor sleep
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight loss

Skin and Hair
- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Acne
- ☐ Recent moles
- ☐ Hair loss
- ☐ Dandruff
- ☐ Fungal infections
- ☐ **Other** hair or skin problem:
  _____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ **Other** heart/vessel problems:
  _____

Respiratory
- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Pain with a deep breath
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm
  Color of phlegm? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other lung problems_____

Gastrointestinal
- ☐ Vomiting
- ☐ Nausea
- ☐ Acid regurgitation
- ☐ Bad breath
- ☐ Hiccup
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Mucous in stools
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Rectal Pain
- ☐ Burning anus
- ☐ Itchy anus
- ☐ Hemorrhoids
- ☐ Anal fissures
- ☐ Other GI Problems_____

Head, Eyes, Ears, Nose, Throat
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  Location: _____
- ☐ Facial Pain
  Location: _____
- ☐ Glasses
- ☐ Poor Vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field

Neuropsychological
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye dryness
- ☐ Excessive tears
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Hearing aid
- ☐ Earaches
- ☐ Discharge from ears
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Grinding teeth
- ☐ Jaws Clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Enlarged thyroid
- ☐ Swollen glands
- ☐ Sores on lips or tongue
- ☐ Gum problems
- ☐ Teeth problems
- ☐ **Other** head or EENT problems:
  _____
  _____

Genito-Urinary
- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Genital itching
- ☐ Sores on genitals
- ☐ Waking to urinate at night?
  How often? _____
- ☐ **Other** Genital/urinary system problems:_____
  _____

Pregnancy and Gynecology

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge
- ☐ Postcoital bleeding
- ☐ Vaginal sores

Date of last Pap_____

- ☐ Breast lumps
- ☐ Nipple discharge

Musculoskeletal

- ☐ Neck Pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ **Other**_____

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Tics
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Irritability
- ☐ Depression
- ☐ Frustration
- ☐ Sadness
- ☐ Anxiety
- ☐ Easily susceptible to stress
- ☐ Vertigo
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Substance abuse
- ☐ Abuse survivor

Have you been ever been treated for emotional problems?
☐ Yes ☐ No

Have you ever considered or Attempted suicide? ☐ Yes ☐ No

Other neurological or psychological Problems:_____
_____

*****ANY HEALTH ISSUES NOT MENTIONED ON THIS FORM:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete your medical history form. The information you provide enables me to thoroughly evaluate, diagnose and treat your condition according to East Asian Medicine. All of your answers are completely confidential and will not be released to any person without your written consent and authorization.