Health History Questionnaire

Date:______________________________

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to my attention that is not asked on this form please note it in the comments section. Thank you. –Yoko

<table>
<tr><td colspan="3">Name:</td><td colspan="3">Email:</td></tr>
<tr><td colspan="3">Address:</td><td colspan="2">City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td>Home Phone:
( )</td><td colspan="2">Work Phone:
( )</td><td>Gender:
Male Female</td><td colspan="3">Date of Birth:
/ /</td></tr>
<tr><td colspan="2">Height:
‘ “</td><td colspan="2">Weight:</td><td colspan="3">Occupation:</td></tr>
<tr><td colspan="4">Family Physician:</td><td colspan="3">Referred by:</td></tr>
<tr><td colspan="2">Emergency Contact (Name):</td><td colspan="3">Emergency Contact Phone:
( )</td><td colspan="2">Have you been treated by acupuncture or oriental medicine before? Yes / No</td></tr>
</table>

What is the main problem(s) you would like me to help you with: ______________________________

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How long ago did this problem begin (be specific) ? ______________________________

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To what extent does this problem interfere with your daily activities (work, sleep,) ? ______________________________

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Have you been given a diagnosis for this problem? If so, what? ______________________________

____

What kind of treatment have you tried? ______________________________

____

Past Medical History:
(Please include date)

Cancer __________ High Blood Pressure __________ Thyroid Disease __________
Diabetes __________ Heart Disease __________ Seizures __________
Hepatitis __________ Rheumatic Fever __________ Venereal Disease __________
Other :______________________________

Surgeries (type of and date) :

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____

Significant Trauma (auto accidents, falls etc.) :

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____

Significant Dental Work (type and date) :

____

Birth History (prolonged labor, forceps delivery, etc.)

____

____

Allergies (drugs, chemicals, foods):____

____

Family Medical History (check):

- Diabetes
- High Blood Pressure
- Stroke
- Asthma
- Cancer
- Heart Disease
- Seizure
- Allergies
- Other: ____

Medicine Taken within the last two months (vitamins, drugs, herbs, etc.)

____

____

Occupational Stress (chemical, physical, psychological, etc.):

____

Do you have a regular exercise program?
- Yes
- No

Please describe:__________________________

____

Please Describe Your Average Daily Diet

Morning ____

Afternoon ____

Evening ____

How many packs of cigarettes do you smoke per day?_________

How much coffee, tea or cola do you drink per week?_________

How much alcohol do you drink per week?__________________

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

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COMMENTS: (Please tell me any other problems you would like to address.)

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Please Check Any Symptoms You Have Had in the Last Three Months

General

- Chills
- Fever
- Sweat easily
- Night Sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar taste or smell
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
- Edema
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Changes in hair or skin
- Ulceration
- Eczema
- Oozing on skin lesion
- Hives
- Pimples
- Recent moles
- Loss of hair
- Dandruff

Other skin or hair problem:

____

Head, Eyes, Ears, Nose and Throat

- Dizziness
- Migraines
- Headaches
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tear
- Discharge from eyes
- Poor hearing
- Ringing in ear
- Ear aches
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Grinding teeth
- Teeth problems
- Jaw clicks
- Concussion
- Recurrent sore throat
- Hoarseness
- Sore on lips or tongue
- Other head or neck problems

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Cardiovascular

- High blood pressure
- Low blood pressure
- Chest discomfort
- Heart palpitation
- Cold hands or feet
- Swelling of hands
- Blood clots
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems

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Respiratory

- Cough
- Asthma/wheezing
- Pain with a deep breath
- Difficulty in breathing when lying down
- Products of phlegm
- Coughing blood
- Pneumonia
- Bronchitis
- Other lung problems:__________

Gastrointestinal

- Bad breath
- Nausea
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation
- Chronic laxative use
- Blood in urine
- Black stools
- Abdominal pain or cramps
- Gas
- Rectal pain
- Hemorrhoids
- Other stomach or intestinal problems

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Genito-Urinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in Flow
- Unable to hold urine
- Dribbling
- Kidney stones
- Impotency
- Changes of sexual drive
- Sores on genitals
- Wake up to urinate
- Any particular color of urine

  ____
- Other genital or urinary system problems:__________

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Musculoskeletal

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

Pregnancy and Gynecological

Number of pregnancies:______
Number of births:___________
Number of miscarriage:______
Number of abortions:________
Age at first menses:_________
Period between menses:______
Duration of menses:_________
First date of last menses:
_____/_____/______

- Heavy periods
- Light periods
- Painful periods
- Irregular periods
- Changes in body/psyche prior to menstruation
- Clots
- Menopause
  Age_____
  Year_____
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Nipple discharge

Neuropsychological

- Seizures
- Numbness
- Weakness
- Sleep disorder
- Concussion
- Bad temper
- Loss of control/Violence
- Vertigo
- Depression
- Easily susceptible to stress
- Poor memory
- Anxiety
- Substance abuse

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

Have you ever considered or attempted suicide?
Yes / No

Other neurological or psychological problems;
____
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