

Patient medical form



HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. GENERAL PATIENT INFORMATION

Date: ____/____/____

Name:

Address:

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Email address:

To retain your health care privacy, may we contact you at these phone numbers? Yes No

If No, what is the best way to reach you to retain your privacy?

Age: ____ Date of Birth: ____/____/____ Place of Birth: _____

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Guardian (if under 18 years of age): _____

Gender: F M Height: ____' ____" Weight: ____ lbs. Marital Status: _____

Occupation: _____ Employer: _____

How did you hear about our office?

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Emergency Contact Name, Phone Number and Relation to Patient:

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

Main Conditions you would like us to help you with, in order of significance:

1.

4.

2.

5.

3.

6.

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How long ago did these problem(s) begin, please be specific:

To what extent do these problems affect your daily activities, such as work, sleep or hobbies?

What kinds of treatment have you tried, and how have they worked?

Have you been given a diagnosis for any of these problems, if so, what?

II. PAST MEDICAL HISTORY

How was your childhood health?

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, falls:

Allergies (food, seasonal, environmental):

Recent Tests (Please indicate test results and date):

Physical

Cholesterol

Prostate

Blood (which)

HIV/STD

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Pap smear Mammography Other: _____

Test Results and Date:

Circle any you have had in the past:

Diabetes Allergies Glaucoma Rheumatic Fever Heart Disease
CVA (Stroke)

Vein condition Asthma Pneumonia Tuberculosis Emphysema
Mumps

Jaundice Gonorrhea Syphilis Bleeding Tendency Measles

Meningitis Chicken Pox Epilepsy Nervous Disorder High Fever

Hepatitis Mononucleosis HIV/AIDS Polio Thyroid Disorder

Paralysis Cancer Migraines Diabetes Hepatitis High Blood

Pressure Lung Disorder Liver Disorder

Kidney Disorder Spleen Disorder Stomach Disorder

Other:

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Immunizations:

Family Medical History: Please circle all that apply in your immediate family

Cancer Diabetes High Blood Pressure Stroke Seizures
Allergies

Asthma Heart Disease Other Major Illnesses:

III. PATIENT PROFILE

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs):

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

Do you have a regular exercise program? If yes, describe:

Are you on a restricted diet? If yes, describe:

How much water do you drink daily?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?

Do you smoke? If yes, how many cigarettes per day?

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Pain Conditions:

Indicate any areas of pain in the body and the location of any scars on the body:

Is the pain sensation:

Sharp Burning Aching Cramping Dull Moving
Fixed Other:

Do any of the following lessen the pain:

Pressure Cold Heat Exercise Other:

Do any of the following worsen the pain:

Pressure Cold Heat Exercise Other:

Please check the following that pertain to you:

Overall Temperature (Kidney Function):

Hot body temperature or sensation Cold hands Sweaty hands

Afternoon flushes

Cold body temperature of sensation Cold feet Sweaty feet Night sweats

Heat in the hands, feet and chest Hot flashes any time of the day Lack of perspiration

Perspire easily Thirsty: for hot or cold drinks

Overall Energy (Lung and Kidney Function):

Difficulty keeping eyes open in the daytime Shortness of breath General weakness

Easily catch colds Low Energy Feel worse after exercise

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Overall Blood Function:

See floaters or floating black spots in the eyes recent moles, unusual moles

Freckles Dizziness Pimples

Heart Function:

Cardiovascular disease High blood pressure Low blood pressure

Chest pain Fainting Palpitations Sores on tip of tongue

Restlessness Anxiety Hard to fall asleep Wake unrefreshed

Nightmares Restless sleep Mental Confusion Restless dreaming

Waking during the night Chest pain traveling to shoulders or down arms

Lung Function:

Profuse nasal discharge: thin/clear/runny thick/white thick/yellow

Cough: Wet or Dry Nose Bleeds Sinus Congestion Dry mouth

Dry, itchy throat Sore throat Dry skin Allergies: to what?

Sneezing Hives Stiff neck Stiff shoulders

Bronchitis Rashes Itching Eczema

Dandruff Sadness Melancholy Difficulty inhale or exhale

Alternating fever and chills Achy feeling in the body Smoke cigarettes

Spleen Function:

Low appetite Changes in appetite Cravings, for what?

Abrupt weight gain Abrupt weight loss Abdominal bloating

Abdominal gas Stomach θ Gurgling Fatigue after eating

Easily bruised Hemorrhoids Pensive/Over-thinking

Worry Prolapsed organs: which organ?

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Spleen, Stomach, Large Intestine, Small Intestine Function:

Loose Stools Incomplete Bowel Movements Constipation
Diarrhea Blood in Stools Undigested food in stools
Mucous in stools Black or tarry stools Chronic use of laxatives: what type of laxative?

Dampness trapped in body:

General sensation of heaviness in body Mental heaviness Mental sluggishness
Mental fogginess Swollen hands Swollen feet Swollen joints
Chest congestion Nausea Snoring Dizziness
Snoring Phlegm production

Stomach Function:

Burning sensation after eating Large appetite Bad breath Vomiting
Sores on lips, tongue or mouth Ulcer (if diagnosed) Belching Acid
Regurgitation Cold sensation in stomach
Hiccoughs Stomach Pain & Heartburn Bleeding, swollen or
painful gums

Liver and Gallbladder Function:

Chest pains Tight sensation in chest Bitter taste in mouth
Anger easily Frustration Depression

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Irritability	Skin rashes	Tingling sensations
Numbness	Muscle Spasms	Muscle Twitching
Muscle Cramping	Seizures	Convulsions
Lump in throat	Teeth Grinding	Alternating diarrhea and constipation
Neck tension	Shoulder tension	Hip pain/Sciatica
Drink alcohol	Recreational drugs (which, how much per week?)	

High pitch ringing in the ears Gallstones, history of or currently

Sexually transmitted diseases (which) Genital sores

Frequently unable to adapt to stress (what causes this stress?)

Headaches: How Often? Describe location: Migraines

Eyes: (Liver Function)

Itchy	Red or Bloodshot	Hot	Dry
Watery	Gritty or sandy feeling	Blurry vision	Decreased night vision
Near-sighted	Far-sighted	Cataracts	Visual Disturbances

Kidney, Urinary Bladder Function:

Frequent cavities	Easily Broken Bones	Poor hearing	Earaches
Painful knees	Weak knees	Cold in knees	Low back pain
Memory problems	Excessive hair loss	Pre-mature grey hair	Low-pitch ringing in the ears
Kidney stones	Bladder infections	Fear	Easily startled
Foot or ankle weakness or pain	Lack bladder control		Sneeze or jump

incontinence

Urination:

How many times per day do you urinate?

Do you wake during the night to urinate?

How many times per night?

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Normal color urine	Dark yellow	Clear	Reddish
Cloudy	Scanty	Profuse	Strong Odor
Burning	Painful	Difficult	Urgent

Libido:

Normal High Low

Women only:

Do you practice birth control? What type and for how long?

Pregnant? Y N Is there a chance you may be pregnant now?

Vaginal discharge: Frequent? Color? Odor?

Regular menstrual cycle? Y N

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable): _____

Average number of days of flow: _____ Average number of days of entire cycle: _____

Uterine bleeding/spotting N0Y 0between periods? How much and how often?

Do you experience any of the following pre-menstrual syndromes?

Nausea Vomiting Water retention Breast swelling

Food cravings Headaches Migraines
Breast0 tenderness

Depression Irritability Anxiety other emotions:

Dull pain, where? _____ Sharp pain, where? _____

Men only:

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Swollen testes

Testicular pain

Impotence

Premature ejaculation

Feeling of coldness or numbness in external genitalia

Other _____

All please fill out:

Please describe your Average Daily Diet:

Breakfast

Lunch

Dinner

Snacks (eaten at what time?):

Please tell us of any other problems you would like to discuss:

Patient Signature: _____

Acupuncturist Signature: _____

Midwest