

Confidential Health History

Today's Date _____

Welcome! We want to make your appointment as pleasant and comfortable for you as possible.
If at any time you have questions regarding your visit, please let us know.

Name _____ E-Mail _____ Phone (H) _____ (W) _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ M _____ F _____ Marital Status _____ # of Children _____

Occupation _____ Height _____ Weight _____ Referred by _____

Primary health complaint _____

Secondary health complaint _____

How long have you had this condition? _____ What brought it on? _____

Does it affect your: work sleep eating other (explain) _____

What activities or times aggravate condition? _____

What activities or times improve condition? _____

What do you believe is wrong with you? _____

What have you done to get relief? _____

Have you been given a diagnosis for the problem by your family physician? (explain) _____

Physician _____ Have you had acupuncture before? _____ Chinese herbal medicine _____

Drugs _____

Vitamins/supplements _____

Herbs _____

AVERAGE DAILY DIET:

Morning	Afternoon	Evening

- HABITS**
- | | | | | |
|----------------------------------|---|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Artificial sweetener | <input type="checkbox"/> Caffeinated coffee/tea | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Cola |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Exercise | <input type="checkbox"/> Salt | <input type="checkbox"/> Tobacco | <input type="checkbox"/> White Flour |

PAST MEDICAL HISTORY (Check all that apply. Please include dates)

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Surgery (list) _____ | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker | _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Major Traumas (car, fall, etc. -list) _____ | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | _____ | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | _____ | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures | _____ | _____ |

FAMILY MEDICAL HISTORY

- | | | | | |
|-------------------------------------|---------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | |

Notes: _____

GENERAL

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Cold feet or legs | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Cravings _____ | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cold lower back | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Strong thirst (cold/hot drinks) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | |
| <input type="checkbox"/> Peculiar tastes/smells _____ | <input type="checkbox"/> Sudden energy drop at _____ (time) | <input type="checkbox"/> Bleed or bruise easily (where) _____ | |

SKIN AND HAIR

- | | | | |
|--|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acne/Pimples | <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Purpura | <input type="checkbox"/> Ulceration |
| | <input type="checkbox"/> Hives | | |

HEAD, EYES, EARS, NOSE, THROAT

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Glasses | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Headaches (<i>where and when</i>)
_____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Lumps in throat |
| | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Copious saliva | <input type="checkbox"/> Recurrent sore throats
_____ per month |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Excessive phlegm (<i>color</i>)
_____ | |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Earaches | | |

CARDIOVASCULAR

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

RESPIRATORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cough: wet – dry; thick – thin (<i>circle</i>) | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight chest |

GASTROINTESTINAL

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Bloating | <input type="checkbox"/> Gas | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mucus |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Burning anus | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | <input type="checkbox"/> Vomiting |

How often do you move your bowels? _____ times a day

Color of stool _____ Texture _____ Shape _____ Does stool float? Yes No**GENITO-URINARY**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Increased libido |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Blood in urine | | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Incomplete urination | | | <input type="checkbox"/> Venereal disease |

Color of urine: clear dark yellow light yellow

How many times a day do you urinate? _____

Density of urine: thick medium watery Wake up to urinate? How often _____ /night; time _____**MUSCULOSKELETAL**

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Back pain (<i>where</i>)
_____ | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Limited range of motion
_____ | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Limited use
_____ | <input type="checkbox"/> Rib pain |
| | <input type="checkbox"/> Knee pain | | <input type="checkbox"/> Shoulder pain |

NEUROPSYCHOLOGICAL

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Concussion _____ | <input type="checkbox"/> Numbness (<i>where</i>) _____ | | <input type="checkbox"/> Tics |

PREGNANCY AND GYNECOLOGY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Age at first menses _____ | <input type="checkbox"/> Duration of flow _____ (<i>days</i>) | <input type="checkbox"/> Number of pregnancies _____ | <input type="checkbox"/> Abortions _____ |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | <input type="checkbox"/> Number of births _____ | <input type="checkbox"/> Vaginal discharge (<i>color</i>)
_____ |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Premature births _____ | <input type="checkbox"/> Vaginal odors |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Menopause _____ (<i>age onset</i>) | <input type="checkbox"/> Miscarriages _____ | |
| <input type="checkbox"/> Periods: <input type="checkbox"/> heavy <input type="checkbox"/> light | <input type="checkbox"/> Changes in body/psyche prior to menstruation _____ | | |
| <input type="checkbox"/> Last menses _____ | Length of cycle _____ | Last PAP _____ | |
| Do you practice birth control? _____ | If so, what type? _____ | For how long? _____ | |

MALE SECTION

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Night urination | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Testicle pain | |