AcuMeD Acupuncture&herbs Clinic

Health History Questionnaire Date:…….

Please help us 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 questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Name (First & Last)		Email	
Home Phone	Cell Phone	Work Phone	
Street	City	State/Zip	
Date of Birth	Age	Height	Weight
Occupation	Family Physician	Referred By	
Emergency Contact - Name (First & Last)	Emergency Contact - Phone	Relation to you	
Health Insurance: Company & Policy Number			

Have you been treated by acupuncture or Oriental medicine before? □Yes □No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep, and sex?
Have you been given a diagnosis for this problem? If so, what?
What other kinds of treatment have you tried?

Name: Date:

PAST MEDICAL HISTORY (please include date)

Significant Illnesses *(please circle all applicable)*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease Other

Surgeries

Significant trauma (auto accidents, falls, etc.)

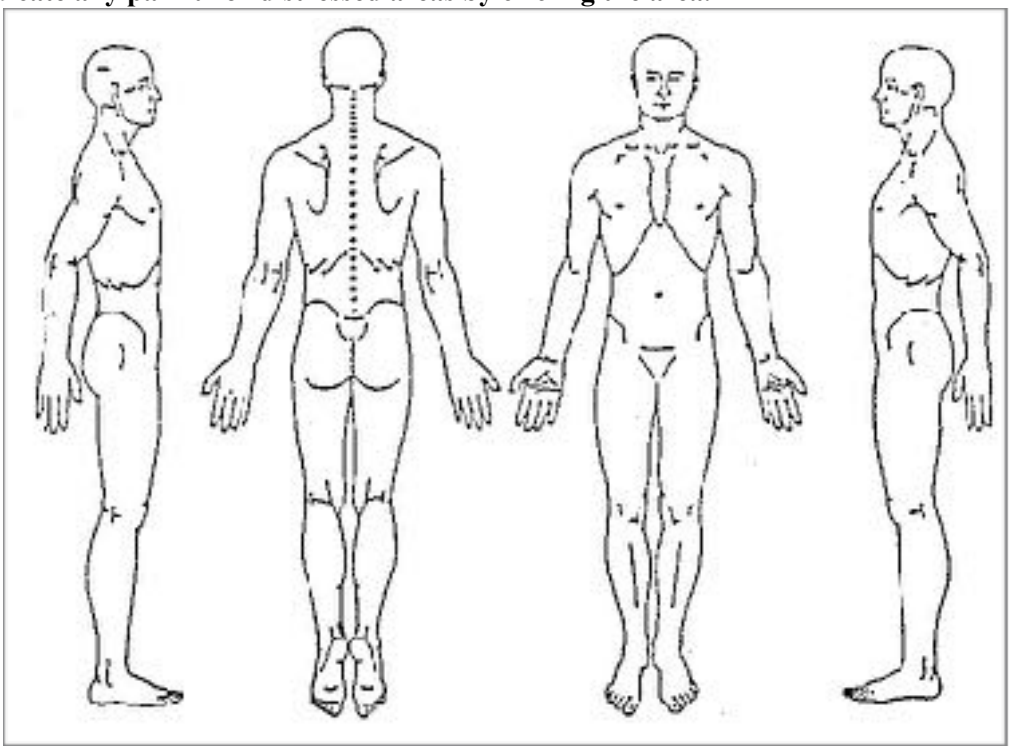
Allergies (drugs, chemicals, foods, Medical treatment)

Family Medical History*(please circle all applicable)*

Diabetes Cancer High Blood Pressure: Heart Disease Stroke Seizures

Asthma Allergies Other:

Please indicate any painful or distressed areas by circling the area.



Please check if you have had (in the last three months):

General

□ Fevers	□ Poor sleeping	□ Fatigue
□ Sweat easily	□ Chills	□ Night sweats
□ Bleed or bruise easily	□ Weight loss	□ Cravings
□ Peculiar tastes or smells	□ Strong thirst (hot or cold drinks)	□ Change in appetite
□ Sudden energy drop (what time of day?)		□ Weight gain

Skin & Hair

□ Rashes	□ Ulcerations	□ Hives
□ Itching	□ Eczema	□ Pimples
□ Dandruff	□ Loss of hair	□ Recent moles
□ Change in hair or skin texture		
□ Any other hair or skin problems?		

Head, eyes, ears, nose, and throat

□ Dizziness	□ Concussions	□ Migraines
□ Glasses	□ Eye strain	□ Eye pain
□ Poor vision	□ Night blindness	□ Color blindness
□ Cataracts	□ Blurry vision	□ Earaches
□ Ringing in ears	□ Poor hearing	□ Spots in front of eyes
□ Sinus problems	□ Nose bleeds	□ Recurrent sore throats
□ Grinding teeth	□ Facial pain	□ Sores on lips or tongue
□ Teeth problems	□ Jaw clicks	□ Headaches (where, when?)
□ Any other head or neck problems?		

Cardiovascular

□ High blood pressure	□ Low blood pressure	□ Chest pain
□ Irregular heartbeat	□ Difficulty in breathing	□ Fainting
□ Cold hands or feet	□ Swelling of hands	□ Swelling of feet
□ Blood clots	□ Phlebitis	□ Palpitation

□ Any other heart or blood vessel problems?

Respiratory

□ Cough	□ Coughing blood	□ Asthma
□ Bronchitis	□ Pneumonia	□ Pain with a deep breath
□ Difficulty in breathing when lying down		□ Production of phlegm What color?

□ Any other lung/breathing problems?

Neuropsychological

□ Seizures	□ Dizziness	□ Loss of Balance
□ Areas of numbness	□ Lack of coordination	□ Poor memory
□ Concussion	□ Depression	□ Anxiety
□ Bad temper	□ Easily susceptible to stress	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

How do you deal with or manage stress on a regular basis?

□ Any other neurological or psychological problems?

Reproductive and gynecologic

Are you pregnant? Yes No

Is it possible that you are pregnant? Yes No

□ Pregnancy	□ Live births	□ Miscarriages
□ Abortions	□ Premature births	□ Age of first menses
□ Period between menses	□ Duration of menses	□ Unusual character (heavy, light)
□ Irregular periods	□ Painful periods	□ Clots
□ Last PAP	□ Vaginal discharge	□ Vaginal sores
□ Breast lumps	□ Menopause Age	

□ Changes in body/psyche prior to menstruation

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

□ If you wish to be treated for infertility, please provide the information below:
How long have you been trying to get pregnant?
When were you given a Western diagnosis of infertility? What is the diagnosis?

What infertility medication have you taken?
What infertility treatments have you tried? How many?

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

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