Health History Questionnaire

Please help me to provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask me. 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! Sarah Steed, L. Ac.

Name: ________________________________

Birth date: _____________ **Age:** ____**Height:** ________**Weight:** _______

Home Phone: ________________**Work Phone:** ________________

Occupation: _____________________ **Marital Status:** ______________

Have you tried acupuncture or Chinese herbal medicine before?

____

Main Problem you would like to address

____

How long has it been since you first noticed any symptoms?

____

To what extent does this problem affect your daily activities (work, sleep, eating, exercise, etc.)?

____

Have you been given a diagnosis for the problem by your family physician?

____

What types of treatment, therapy or medication have you tried for this problem?

____

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____

____

Past Medical History:

__Asthma	__Hepatitis	__Thyroid Disease
__Cancer	__High Blood Pressure	__Low Blood Pressure
__Heart Disease	__Seizures	__Venereal Disease
__Diabetes	__High Cholesterol	__HIV/AIDS
__Fainting Spells	__Irregular Heartbeat	

__ Do you need antibiotics for heart disease prevention when you visit the dentist?

Accidents or significant trauma (describe)

____

____

Blood clots or Phlebitis____

Surgeries (type & year)

____

Allergies

____

List medications you have taken in the past two months (include vitamins, herbs, drugs, etc.)

____

Other relevant medical history

____

Family Medical History (parents, siblings, grandparents)

__Asthma	__Hepatitis	__Thyroid Disease
__Cancer	__High Blood Pressure	__Low Blood Pressure
__Heart Disease	__Seizures	__Other
__Diabetes	__High Cholesterol	__Alcoholism
__Fainting		

Occupational stress factors (physical, psychological, chemical

____

Lifestyle

Describe your overall or general emotional status

____

Social relationships (support network)_____________________________

Do you follow a regular exercise program? _____If so, please describe:

____

____

Describe your average daily diet: number of meals____

What do you snack on and how much?

____

Typical Meal:

Breakfast: ____

Lunch: ____

Dinner: ____

Please check any of the following habits that apply. How often and how much:

Alcohol: _____________________**Cigarette smoking:** ________________

Coffee, tea, cola (caffeine beverages): _____________________________

Cravings: ____

Are you generally warm or cold? __________________________________

What season do you prefer? _____________________________________

Generally how thirsty are you? ___________________________________

What temperature is your fluid preference? _________________________

Sleep patterns: How much sleep do you need? _______________________

Do you awake feeling refreshed? _________________________________

Do you suffer from insomnia frequently? _____ If so describe

____

Do you experience any of the following?

Tremors_______ **Recent weight change**_____ **Sweat easily**__________

Poor balance Bleeding or bruise easily____________________________

Do you sigh frequently?____

Do you have any areas of numbness or tingling?______________________

Skin and Hair

Rashes____ Ulcerations_____ Hives_____
Eczema__ Dry hair__ Hair loss_____
Psoriasis__ Perspiration (night sweats, etc.)______

Head, Eyes, Ears, Nose, Throat
Dizziness___ Headaches (location).____________________
Lack of coordination_______________________________________
Spots in front of eyes____ Dry eyes_____ Poor vision______ Red Eyes_____
Night blindness_____ Cataracts____ Glasses_______ Blurry vision______
Earaches______ Ringing in ears___________ Poor hearing_______
Chronic sinus drainage________________ Sinus pain______________
Recurrent sore throat________________ Dry Nose_______________
Nose Bleeds______________ Grinding teeth____________________
Sores on lips, tongue or gums_____________________ Facial pain________
Teeth problems___________________ Jaw clicks_______________________

Cardiovascular
Irregular heart beat_______________Palpations___________ Fainting______
Cold hands or feet____________ Swelling of hands or feet_____________
Difficulty in breathing___________________ Varicose veins______________

Respiratory
Cough_______________ Difficulty breathing when lying down____________
Shortness of breath with daily activity___________ Sinus drainage_______
Excessive phlegm (describe)____
Any other lung problems____

Gastrointestinal

Describe your appetite (poor, excessive)_______________________________
Do you get nauseated often?____
Diarrhea_____________ Constipation______________ Gas___________
Vomiting________________ Belching_______ Abdominal distention_______
Indigestion/reflux_______________________________
Bad breath__________ Rectal pain___________ Hemorrhoids___________
Taste in mouth (sour, bitter, sweet etc)_______________________________
Abdominal pain or cramps____
Stool, bowel movement (frequency)___________________________________
Any other problems with stomach or intestines_________________________

Genitourinary

Pain on urination_______ Frequent urination_____ Blood in urine_______
Urgency to urinate____ Unable to empty bladder______Kidney stones_____
Decrease in flow____________ Impotence __________Sores on genitals____

Do you wake up at night to urinate (how many)__________________________

Any other genital or urinary problems___________________________________

Reproductive and Gynecologic - Please answer even if you have reached menopause or have had surgery (partial or complete)

Premenstrual changes (mood swings, breast tenderness, bloating, cramps)
____

Age of first menses______________ Age of menopause___________________
Length of cycle_____________ Duration of bleeding_____________________
Menstruation: Color___________ Amount______________ Cramps___________
Clots___________Number of pregnancies____ Number of live births________
Miscarriages______Do you practice birth control____ If so what type?_____
Infertility______________Hot flushes_________________________
Any other GYN problems____
Date of last menstrual period____
Are you pregnant________

Muscular-skeletal

Neck pain_______Knee pain________ Foot/ankle_________ Hand/wrist______
Low back pain/soreness___________ Upper back pain____________________
Shoulder pain ___________ Hip pain________ Muscular pain/weakness______

Other Comments (use back of sheet if needed)

____

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