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?

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_____

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)

_____
