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___________________________________

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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