Health History Questionnaire

Name:____Date:____________________
Have you tried acupuncture or Chinese herbal medicine before?____________When?__________

Present Condition

Main problem(s) you would like to address: ____
____
Date it began or when you first noticed symptoms: ____
How does this condition affect you (interfere with work, sleep, appetite, etc.) ________________
____
Have you ever received treatment for this condition?___________If yes, when? _______________
From whom? ____
What was the diagnosis? ____
What were the results of the treatment? ____
____
Has the condition gotten: _____Better ______Worse ______It's about the same

What are your most important health problems? Please list in order of importance.
1.___________________________________2____
3.___________________________________4____

Personal Medical History

Major surgeries, fractures and other serious injuries. Please list and give approximate dates for each condition.

____
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____
____
____
Have you experienced any significant trauma ? (i.e., divorce, change of residence, injury, loss of job, death in family, bankruptcy.)____

Weight__________lbs. Height___________Any recent weight gain or loss? _____________________

Please mark box with 'P' for past use and 'C' for current use.
_____Cigarettes _____Soft Drinks _____Salt _____Sugar _____Coffee
_____Black tea ____ ____Alcohol ____ _____Recreational Drugs _____Black Tea

Genevieve Allen, L.Ac. 102 NW 99th St. Vancouver, WA 98665.

Do you follow a regular exercise program?_______ Please describe:________________________________
____
____

Do you do any form of deep relaxation regularly? Yes_____No____Yoga_____Tai Chi______
______Meditation______Qi Gong______Guided Relaxation______Breath work______

Do you follow any particular religious or spiritual practice? Please explain ____________________
____
____
____

Current Medications: Do you take or use:

Laxatives	Y	N	Pain Relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite Suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid Medication	Y	N	Sleeping Pills	Y	N

Please list any prescription medications, over the counter medications, vitamins and other supplements you are taking. Feel free to attach a list of your current medications.

1.____________________________________ **2.**__________________________________
3.____________________________________ **4.**__________________________________
5.____________________________________ **6.**__________________________________

Please check the appropriate box as to a past (P) or current (C) medical condition.

P	C		P	C	
☐	☐	HIV virus	☐	☐	Respiratory diseases
☐	☐	Heart disease or heart attack	☐	☐	Pneumonia or emphysema
☐	☐	Rheumatic fever	☐	☐	Tuberculosis
☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Hepatitis
☐	☐	Epilepsy or convulsions	☐	☐	Peptic ulcer or pancreatitis
☐	☐	Kidney or bladder problems	☐	☐	Anemia/other blood disorder
☐	☐	Diabetes	☐	☐	Bleeding disorder
☐	☐	Tumor or cancer	☐	☐	Jaundice
☐	☐	Hernia	☐	☐	Do you have a pacemaker?
☐	☐	Thyroid disorder	☐	☐	Do you have surgical implants
☐	☐	Venereal disease	☐	☐	Genital disorders
☐	☐	Congenital abnormalities	☐	☐	Gynecological disorders
☐	☐	Have you had a change in bowel or bladder habits?			
☐	☐	Do you have any sores that won't heal?			
☐	☐	Do you have any unusual bleeding or discharge?			
☐	☐	Do you have any indigestion or difficulty swallowing?			
☐	☐	Do you have any obvious change in a wart or mole?			
☐	☐	Do you have a nagging cough or hoarseness?			
☐	☐	Do you get regular physical checkups from a personal care physician? Last visit?____________________			

Please check the appropriate box for a past (P) or current (C) medical condition.

P	C	Condition
☐	☐	Cough
☐	☐	Asthma
☐	☐	Fatigue
☐	☐	Difficulty breathing
☐	☐	Sinus Problems
☐	☐	Phlegm
☐	☐	Nasal problems
☐	☐	Sore throat
☐	☐	Loss of Voice
☐	☐	Hoarse Voice
☐	☐	Sneezing
☐	☐	Nose Bleeds
☐	☐	Skin problems
☐	☐	Intolerance to weather changes
☐	☐	Fever and/or chills
☐	☐	Red eyes
☐	☐	Dry eyes
☐	☐	Stiff neck
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Difficulty falling asleep
☐	☐	Restless sleep
☐	☐	Nightmares
☐	☐	Heat sensation in hands/feet
☐	☐	Hot Flashes
☐	☐	Unusual/excessive sweating
☐	☐	Night Sweating
☐	☐	Excessive laughter
☐	☐	Anxiety
☐	☐	Fainting
☐	☐	Pale Face
☐	☐	Eye problems
☐	☐	Mood swings
☐	☐	Loss of sensation (any body part)
☐	☐	Excessive worry
☐	☐	Bitter taste in mouth
☐	☐	Easily irritable or angry
☐	☐	Headaches
☐	☐	Twitching/spasms of muscles
☐	☐	Facial redness
☐	☐	Brittle Nails
☐	☐	Pain in the rib area
☐	☐	Hernia
☐	☐	Dizziness
☐	☐	Lump in throat/hard to swallow
☐	☐	Stomach pain
☐	☐	Bloating after meals
☐	☐	Joint pain
☐	☐	Hiccups
☐	☐	Gas
☐	☐	Belching
☐	☐	Heartburn (acid reflux)
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Mouth sores
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Loose Stool
☐	☐	Dry Stool
☐	☐	Watery stool
☐	☐	Foul Yellow Stool
☐	☐	Mucoid Stool
☐	☐	Bloody stool/tarry stool
☐	☐	Burning anus
☐	☐	Hemorrhoids
☐	☐	Bruise Easily
☐	☐	Weakness of limbs (arms & legs)
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Easily tired (fatigue)
☐	☐	Food cravings
☐	☐	Pain with hunger
☐	☐	Pain after eating
☐	☐	Hunger without desire to eat
☐	☐	Loss of ability to taste
☐	☐	Sweat or sticky taste
☐	☐	Sour taste
☐	☐	Increase of thirst
☐	☐	Absence of thirst
☐	☐	Thirst with no desire to drink
☐	☐	Prefer hot drinks
☐	☐	Prefer cold drinks
☐	☐	Cold sensations in hands or feet
☐	☐	Edema (water retention)
☐	☐	Ringing in Ears
☐	☐	Hearing loss/deafness
☐	☐	Back soreness
☐	☐	Knee soreness/weakness
☐	☐	Easily frightened
☐	☐	Frequent urination
☐	☐	Night urination

- ☐ ☐ Urgency to urinate
- ☐ ☐ Copious urination
- ☐ ☐ Scanty urination
- ☐ ☐ Difficulty in Urination
- ☐ ☐ Blood in the urine
- ☐ ☐ Stones in the Urine
- ☐ ☐ Decreased/increased sexual drive
- ☐ ☐ Poor memory
- ☐ ☐ Hair loss
- ☐ ☐ low back pain

For Men Only

P C

- ☐ ☐ Premature ejaculation
- ☐ ☐ Impotence
- ☐ ☐ Prostate problems

For Women Only

- ☐ ☐ Vaginal discharge
- ☐ ☐ Breast swelling or pain
- ☐ ☐ Uterine fibroids?
- ☐ ☐ Ovarian cysts?
- ☐ ☐ Fibrocystic breast condition?

Menstruation

- ☐ ☐ Early
- ☐ ☐ Delayed
- ☐ ☐ No periods
- ☐ ☐ Irregular periods (late/early)
- ☐ ☐ Cramps
- ☐ ☐ Mood swings
- ☐ ☐ Heavy/excessive bleeding
- ☐ ☐ Scanty, light periods
- ☐ ☐ Bright red blood
- ☐ ☐ Brown red/rusty colored blood
- ☐ ☐ Dark red blood
- ☐ ☐ Clots
- ☐ ☐ Backache
- ☐ ☐ Birth control: type__

Are you pregnant?________Due date?_____________ Have you miscarried in the past 12 momths ?
____ ____________

Age at start of menses _________________________

Date of last menstrual cycle ____________________

Are you experiencing menopausal symptoms? Please explain. ____________________________________

____

Are you on Hormone Replacement Therapy?_____ If so,which type? _______________________________

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