PLEASE FILL OUT CAREFULLY!!

Oriental Medicine often uses unusual or seemingly insignificant body changes to diagnose the cause of health problems. Some of the following questions **may not appear** to be related to your primary health problem, but your best answer to each question will provide us with the information we need to make a precise diagnosis.
HEALTH HISTORY QUESTIONNAIRE v-015a

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

I. General Patient Information

Date: ___/___/___  Name: ____________________________________________

Address: _______________________________________________________

City, State, Postal Code: ___________________________________________________________________

Home Phone: (____)________________________  Work Phone: (____)________________________

May we contact you: ☐ at home, ☐ at work, ☐ email (provide address) _______________________

Age: _____  Date of Birth: ___/___/___  Place of Birth: _______________________________________

Gender: ☐ M  ☐ F  ☐ Married  ☐ Single  Height: ___’___”  Weight: _____lbs.

Occupation: __________________________  Employer: __________________________

Hours worked per week _____  Is your health complaint related to work? ☐ Yes  ☐ No  ☐ Maybe

How did you hear about our office? _______________________________________________________

Guardian (if under 18): ___________________________________________________________________

Person to notify in an emergency_________________________ Relationship ___________________

Daytime phone for above person (____)________________________

Major Complaint(s), in order of significance to you:

1. ______________________________________  4. ______________________________________

2. ______________________________________  5. ______________________________________

3. ______________________________________  Additional: _______________________________

How do these conditions impair your daily activities?_______________________________________

______________________________________________________________________________________

II. Patient Medical History

How was your childhood health?____________________________________________________________

Hospital Visits/Stays:____________________________________________________________

____________________________________________________________
Recent tests: (please indicate test results and date below)

- Physical
- Cholesterol
- Prostate
- Blood (which?)
- HIV/STD
- Pap smear
- Mammography
- Other:____________________

Test Results and Date:_______________________________________________________________________

Check any you have had in the past:

- Diabetes
- Heart Disease
- Asthma
- Jaundice
- Syphilis
- Meningitis
- Other lung illnesses
- Vasectomy
- Other:____________________

- Allergies
- CVA (stroke)
- Pneumonia
- Gonorrhea
- Measles
- HIV
- High fever
- Cancer
- Sleep Apnea
- Other:__________________________________

- Glaucoma
- Vein condition
- Tuberculosis
- Mumps
- Chicken pox
- Polio
- Migraines
- Other liver illnesses
- Other heart illnesses
- Other kidney illnesses

Immunizations:______________________________________________________________________________

Surgeries:___________________________________________________________________________________

Serious injuries or accidents:_________________________________________________________________

III. Patient Profile

Please clearly mark any areas of pain (with xxxx’s), scars (with ------) and numbness (with OOOO’s).

Is the pain:
- Sharp
- Burning
- Aching
- Cramping
- Dull
- Moving
- Fixed Other:____________________

Do the following lessen the pain?
- Pressure
- Cold
- Heat
- Exercise
- Other:____________________

Do the following worsen the pain?
- Pressure
- Cold
- Heat
- Other:____________________

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ’s function).

Overall Energy, Dampness

- Low energy
- General weakness
- Difficulty keeping eyes open in the daytime
- Feel worse after exercise
- Overall achy feeling in the body
- Easily catch colds
- Low libido
- Excessive libido
- General sensation of heaviness in the body
- Mental heaviness
- Mental fogginess
- Dizziness
- Swollen joints (where? _________________)
- Edema (where? _________________)
- Skin is often damp or moist
**Overall Temperature (Kidney function)**
- Cold body temperature (more sensitive to cold than the average person)
- Cold sensation in the knees
- Can get chilled to the bone (hard to get warm again)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day or night
- Hot body temperature (sensation)
- Alternating fevers and chills
- Take water to bed
- Excessive Thirst
- Easily Perspire
- Excessive Perspiration
- Rarely Perspire... even when exercising
- Graying Hair

**Eyes, Ears, Nose, Throat**
- Headaches
- Migraines
- Seasonal Allergies
- Continuous Allergies (dust, etc)
- Sinus congestion
- Nasal discharge
- Sneezing
- See floating black spots
- Decreased night vision
- Twitch in eye(s)
- Dry:
  - lips
  - mouth
  - nose
  - throat
- Eyes:
  - Itchy
  - Bloodshot
  - Dry
  - Watery
  - Gritty
  - See floating black spots
  - Decreased night vision
  - Twitch in eye(s)
- Heart & Circulation function:
  - Mental confusion
  - Chest pain
  - Chest pain traveling to shoulder
  - Drink coffee # of cups per week: ______
  - Difficulty falling asleep
  - Difficulty keeping asleep
  - Nightmares
  - Wake unrefreshed
  - Anxiety
  - Restlessness
  - Palpitations
  - Chest tightness
  - Sores on the tip of the tongue
  - Pain radiating down the arm
  - Varicose Veins, where?
  - Spider Veins, where?
- Lung function:
  - Difficulty breathing
  - Shortness of breath
  - Cough
  - Chest congestion
  - Asthma: ongoing
  - in the past
  - Smoke cigarettes (# of cigarettes per day: ______)
  - Chew tobacco
  - Sadness
  - Melancholy
  - Dry Skin
  - Cracks in hands or feet
  - Sleep Apnea
- Digestive Power / Stomach function:
  - Low appetite
  - Excessive appetite
  - Abrupt weight gain
  - Abrupt weight loss
  - Fatigue after eating
  - Easily bruised
  - Hemorrhoids
  - Over-thinking
  - Worry
  - Nose Bleeds
  - Other bleeding issues (describe)
  - Prolapsed organs (previously diagnosed, which organs?)
  - Feel worse before BM
  - Feel better before BM
  - Blood in stools
  - Mucus in stools
  - Undigested food in stools
  - Frequent BM # per day
- Large Intestine, Small Intestine function:
  - Loose stools
  - Constipated
  - Diarrhea
  - Incomplete BM (Bowel Movement)
  - Alternating diarrhea and constipation
  - Feel worse before BM
  - Feel better before BM
  - Blood in stools
  - Mucus in stools
  - Undigested food in stools
  - Frequent BM # per day
Liver, Gall Bladder function:
- Anger easily
- Frustration
- Depression
- Irritability
- Pain in the ribs
- Tightness in the chest
- Bitter taste in the mouth
- Weak fingernails
- Muscle spasms
- Twitching
- Cramping
- Recreational drugs (Which? ________________)

Kidney, Urinary Bladder function:
- Frequent cavities, other dental problems (past or present)
- Easily broken bones
- Weakness in low back
- Memory problems
- Excessive hair loss
- Urination:
  - Dark yellow (often)
  - Reddish
  - Blood in Urine
  - Cloudy
  - Scanty
  - Profuse
  - Interrupted
  - Weak Stream
  - Sexually transmitted disease (Which? ________________)

Muscle/Skeletal
- Neck tension
- Pain
- Limited Range-of-Motion in neck
- Shoulder tension
- Pain
- Limited Range-of-Motion in shoulder
- Upper back tension
- Pain
- Muscle weakness, where__________________________
- Loss of muscle function or paralysis, where________________________

Women only:
Do you experience any of the following pre-menstrual syndromes (PMS)?
How many days before period does the PMS usually start? _______ days.
- Nausea
- Vomiting
- Water retention
- Breast swelling
- Food cravings
- Headaches
- Migraines
- Breast tenderness
- Depression
- Irritability
- Anxiety
- Other emotions: ________________
- Dull pain, where?__________________________
- Sharp pain, where?__________________________

Menstrual cycle:
- Irregular menstrual cycle: For _____ # of years, ____ # of months
- Regular menstrual cycle? Pregnant? Yes No
- Number of children: _____
- Number of pregnancies: _____
- Age of first menstruation: _____
- Age of menopause (if applicable): _____
- Average number of days of flow: _____
- Average number of days of entire cycle: _____ to _____
- Severe Menstrual cramps
- Mild Menstrual cramps
- Bleeding between periods
- Unusual vaginal discharges (please describe)
### Women please fill in the following menstrual chart:

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color (bright red, pale, brown, rusty, dark, purple, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of flow (heavy or light)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain/cramps (location, dull, sharp, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clots (large, small, black, purple, red, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting (check if yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea (check if yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Men only:

- Swollen testes
- Testicular pain
- Impotence
- Premature ejaculation
- Feeling of coldness or numbness in external genitalia
- Other
- Erectile Dysfunction (ED)
- Vasectomy
- Unusual discharges from the penis

### Life Style Choices:

- Drink caffeinated beverages, # per day ___
- Drink or use artificial sweeteners
- Exercise: mild moderate vigorous # of hours of exercise per week ______
- Diet: vegetarian, vegan, Foods that are avoided or excluded_________________________

### Medications

- Antacids
- Antibiotics
- Aspirin
- Birth Control Pills
- Blood Thinning Pills
- Cortisone
- Cough Medicine
- Digitalis
- Hormones
- Insulin, Diabetic Pills
- Iron
- Laxatives
- Pain Med.
- Sleeping pills
- Blood Pressure Med.
- Tranquilizers
- Vitamins
- Water Pills
- Weight Reduction Pills
- Thyroid Med.

Please list all other prescriptions, over the counter medications, and supplements which you use. (if you have a written list please give it to the receptionist to be copied)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other Comments: _________________________________________________________

________________________________________________________________________

Patient Signature:________________________________________________________