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. ________________
2. ________________
3. ________________
4. ________________
5. ________________

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	❑Allergies	❑Glaucoma	❑Rheumatic Fever
❑Heart Disease	❑CVA (stroke)	❑Vein condition	❑Thyroid disorder
❑Asthma	❑Pneumonia	❑Tuberculosis	❑Emphysema
❑Jaundice	❑Gonorrhea	❑Mumps	❑Bleeding tendency
❑Syphilis	❑Measles	❑Chicken pox	❑Nervous disorder
❑Meningitis	❑HIV	❑Polio	❑Mononucleosis
❑Epilepsy	❑High fever	❑Hepatitis	❑Multiple Sclerosis
❑Paralysis	❑Cancer	❑Migraines	❑High blood pressure
❑Other lung illnesses	❑Other liver illnesses	❑Other heart illnesses	❑Other kidney illnesses
❑Vasectomy	❑Sleep Apnea	❑ Shingles	❑Anemia

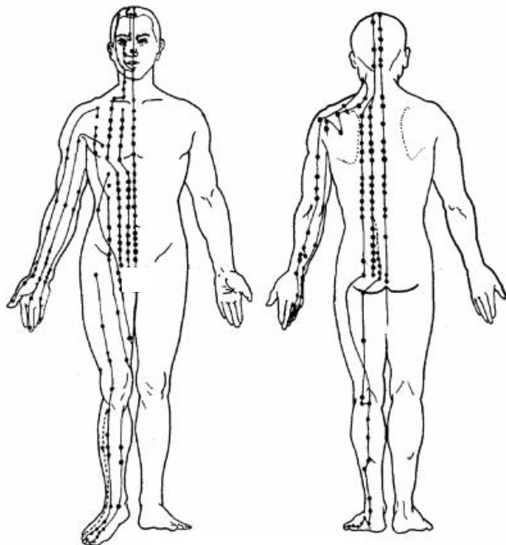
❑Other:________________________________

Immunizations:____

Surgeries:____

Serious injuries or accidents:____

III. **Patient Profile**



Please clearly mark any areas of pain (with xxxxx'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
Dry: ❑lips ❑mouth ❑nose ❑throat
Eyes: ❑Itchy ❑Bloodshot ❑Dry ❑Watery ❑Gritty
❑See floating black spots ❑Decreased night vision
❑Twitch in eye(s)

❑High pitched ringing in ears
❑Low pitched ringing in ears
❑Ear aches
❑Mouth sores ❑Tongue sores ❑Bad breath
❑Bleeding, swollen, painful gums
❑Sore throat ❑Phlegm in throat
❑Difficulty Swallowing
❑Jaw Pain (TMJ)

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

❑Acid reflux ❑Heart burn
❑Burning sensation after eating
❑Stomach Pain ❑ Nausea ❑Vomiting
❑Abdominal bloating ❑Belching
❑Passing gas ❑Hiccoughs ❑Gurgling noise in the stomach ❑Ulcer (diagnosed)
❑Feel better after eating
❑Feel better before eating

❑Other bleeding issues (describe)____________________________________
❑Prolapsed organs (previously diagnosed, which organs? ______________________________

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
❑Mucous 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
❑Tingling sensation ❑Numbness
❑Weak fingernails
Muscle: ❑spasms ❑twitching ❑cramping
❑Recreational drugs (Which? ___________________)
❑Gall stones (❑history or ❑current)
❑Gallbladder removed
❑Seizures ❑Convulsions
❑Skin rashes, where?___________________
❑Drink alcohol
❑Headache at the side(s) of the head
❑PMS symptoms (more detail below)
❑Restless Leg Syndrome
❑Exposure to toxicity
❑Cold Hands ❑ Cold Feet

Kidney, Urinary Bladder function:

❑Frequent cavities, other dental problems (past or present)
❑Easily broken bones
❑Weakness in low back
❑Memory problems
❑Excessive hair loss
❑Kidney stones
❑Wake during the night twice or more to urinate
❑Lack of bladder control
❑Fear
❑Easily startled

Urination:

❑Dark yellow (often)
❑Reddish ❑Blood in Urine
❑Cloudy
❑Scanty
❑Profuse
❑Interrupted
❑Weak Stream
❑Sexually transmitted disease (Which? ___________________
❑Burning
❑Painful
❑Difficult
❑Urgent
❑Frequent
❑Strong odor
❑Discharge
❑Bladder infections

Muscle/Skeletal

❑Neck tension ❑Pain
❑Limited Range-of-Motion in neck
❑Shoulder tension ❑Pain
❑Limited Range-of-Motion in shoulder
❑Upper back tension ❑Pain
❑Painful knees
❑Weak knees
❑Low back pain
❑Hip pain
❑Pain radiating down leg
❑Pain in Hands ❑ Pain in Feet
❑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 ❑Bleeding between periods
❑Mild Menstrual cramps ❑Unusual vaginal discharges (please describe)_____

Women please fill in the following menstrual chart:

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

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

Please check the box if you take any of the medications below.

❑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:______________________________________