

LIFE ACUPUNCTURE AND ORIENTAL MEDICINE

625 AYRAULT RD FAIRPORT, NY 14450

585.465.1056

LIFEACUPUNCTURE.NY@GMAIL.COM

Health History Questionnaire

PATIENT INFORMATION	CONTACT INFORMATION
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Company name _____ Primary physician _____ Physician phone number _____ How did you hear about us? _____ _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____ May we contact you for appointment reminders? _____ Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work phone _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment? 1- _____ 2 - _____ 3 - _____ How is your sleep? _____ _____ How is your digestion? _____ _____ List medications or vitamin supplements you are taking. _____ _____ List serious illnesses, accidents or surgeries. _____ _____ Check illnesses that have occurred in blood relatives. <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease	Check symptoms you have or have had in the last year: <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Dizziness <input type="checkbox"/> Easily startled <input type="checkbox"/> Excessive worry <input type="checkbox"/> Excessive anger <input type="checkbox"/> Excessive fear <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Nervousness/irritability <input type="checkbox"/> Overwhelmed by life Check conditions you have or have had in the past: <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes How long has it been since you have had a complete medical exam? _____
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HEALTH HISTORY...CONTINUED

Check symptoms you have or have had **in the last year:**

MUSCLE/JOINT/BONES

- Tremors c Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms
- Back or Hips
- Legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Previous abortion
- Scanty menstrual flow

Could you be pregnant? _____

Date of last PAP: _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____

