Health History Questionnaire

NAME	MALE o FEMALE o
ADDRESS	AGE
HOME TELEPHONE	E-mail Address
CELLPHONE	MARITAL STATUS
WORK TELEPHONE	MARRIED DATE(S)
OCCUPATION	DIVORCED DATE(S)
DATEOF BIRTH	WIDOW(ER) DATE(S)
REFERRED TO THE ACUPUNCTURE CLINIC BY:	PLACE OF BIRTH

FAMILY HEALTH HISTORY

Family Member	Age	Illnesses, Surgeries or Hospitalizations	Cause of Death (Age)
MOTHER'S FATHER			
MOTHER'S MOTHER			
FATHER'S FATHER			
FATHER'S MOTHER			
MOTHER			
FATHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			

YOUR HEALTH HISTORY

NAME: _____

CONCERN, DISEASE, ILLNESS OR ACCIDENT	YES OR ALWAYS	SOME-TIMES	NEVER	SINCE WHEN	DETAILS YOU THINK WE MAY NEED TO KNOW
MEASLES					
MUMPS					
CHICKENPOX					
WHOOPINGCOUGH					
SCARLET FEVER					
RHEUMATIC FEVER					
MONONUCLEOSIS					
LYME DISEASE					
BROKEN BONES					
STITCHES					
CAR ACCIDENTWITH INJURIES					
SURGERIES					
HOSPITALIZATIONS					
EVER BEEN IN SHOCK					
CHILDHOOD HYPERACTIVITY					
CHILDHOOD ALLERGIES					
BIRTH TRAUMA					
CHILDHOOD TRAUMA					
PNEUMONIA					
CHRONIC COUGHING					
COUGHING BLOOD					
PLEURISY					
BRONCHITIS					
EMPHYSEMA					
ASTHMA					
POLIO					
CONSTIPATION					
DIARRHEA					
FLATULENCE					
HEMORRHOIDS BLEEDING					
BLACK STOOLS					
COLITIS					
CROHN'S DISEASE					
DIVERTICULOSIS					
HEARTBURN/ACID REFLUX					
NAUSEA					
HAIR DRY OR OILY					
DANDRUFF					
NAILS SOFT/SPLIT/CRACK					
BITE NAILS					
POOR CIRCULATION					
FAINTING SPELLS					

YOUR HEALTH HISTORY

NAME: _____

CONCERN, DISEASE, ILLNESS OR ACCIDENT	YES OR ALWAYS	SOME-TIMES	NEVER	SINCE WHEN	DETAILS YOU THINK WE MAY NEED TO KNOW
EPILEPSY OR CONVULSIONS					
CONCUSSION					
PARTOF BODY TREMOR OR JUMP					
PART BODY NUMB OR PARALYIZED					
CHRONIC HEADACHES					
MIGRAINE HEADACHES					
ANY EYE INJURY OR DISEASE					
EYE GLASSES OR CONTACT LENSES					
EYESIGHT GETTING WORSE					
PAIN OR ITCHING IN EYES					
EYES WATERY OR TOO DRY					
ANY DIFFICULTIES HEARING					
EARACHES					
RINGING OR BUZZING IN EARS					
VERTIGO					
MOTION, AIR OR SEASICKNESS					
ANY DENTAL GUM PROBLEMS					
MOUTH OR TONGUE SORES					
LOSS OF TASTE					
LOSS OF SMELL					
FREQUENT COLDS/SORE THROATS					
SINUS PAIN OR BLOCKED SINUS					
RUNNY NOSE, SNEEZING					
NOSEBLEEDS					
COUGH UP MUCOUS					
VOICE HOARSE					
SPEECH DEFICIT					
READING DIFFICULTIES					
ENLARGED GLANDS					
INFECTIONS/BOILS					
BELCHING					
BAD BREATH					
ABDOMINAL PAIN					
ABDOMINAL SWELLING (BLOATING)					
LOSS OF OR EXCESS APPETITE					
DIFFICULTY SWALLOWING					
INDIGESTION					
HEPATITIS					

YOUR HEALTH HISTORY

NAME: _____

CONCERN, DISEASE, ILLNESS OR ACCIDENT	YES OR ALWAYS	SOME-TIMES	NEVER	SINCE WHEN	DETAILS YOU THINK WE MAY NEED TO KNOW
LIVER OR GALLBLADDER DISEASE					
GALLSTONES					
ULCER					
DIABETES					
HERNIA					
HIGH OR LOW BLOOD PRESSURE					
PALPITATIONS					
IRREGULAR HEART BEAT					
DIZZINESS					
NIGHT SWEATS					
CHEST PAIN					
SHORTNESS OF BREATH					
MUSCLE CRAMPS					
VARICOSE VEINS					
BACKACHE					
PAIN IN KNEES					
PAIN IN FEET					
SWELLING OF FEET/ANKLES					
SWELLING OF FACE/HANDS					
COLD OR HOT HANDS					
COLD OR HOT FEET					
URINARY FREQUENCY					
NIGHT FREQUENCY					
URINARY BURNING					
DIFFICULTY URINATING					
URINARY INFECTIONS					
KIDNEY STONES					
SEXUALLY TRANSMITTED DISEASE					
HERPES					
CLOUDY, DARK OR BLOODY URINE					
TROPICAL DISEASES					
PARASITIC INFECTIONS					
INSOMNIA					
WEIGHT CHANGE (OVER 10LBS)					
TUMORS OR GROWTHS					
SKIN DISEASES					
SKIN BRUISES EASILY					
OILY OR DRY SKIN					
ITCHY SKIN					
SKIN ERUPTIONS OR RASH					

YOUR HEALTH HISTORY

NAME: _____

CONCERN, DISEASE, ILLNESS OR ACCIDENT	YES OR ALWAYS	SOME-TIMES	NEVER	SINCE WHEN	DETAILS YOU THINK WE MAY NEED TO KNOW
SKIN HEALS SLOWLY					
SHINGLES					
LONG TERM MEDICATIONS					
'RECREATIONAL' DRUGS					
HAVE A BAD MEMORY					
HAVE TROUBLE CONCENTRATING					
DIFFICULTY MAKING PLANS					
DIFFICULTY MAKING DECISIONS					
OFTEN DEPRESSED					
OFTEN ANXIOUS OR WORRIED					
OFTEN HOPELESS OR NEGATIVE					
DIFFICULT TO RELAX					
EXCERCISE INFREQUENTLY					
CRY EASILY					
NERVOUS WITH STRANGERS					
FRIGHTENING DREAMS					
SHY OR SENSITIVE					
DISLIKE CRITICISM					
LOSE TEMPER EASILY					
EASILY FRUSTRATED OR ANNOYED					
DIFFICULTIES AT WORK					
DIFFICULTIES AT HOME					
SEXUAL DIFFICULTIES					
DIFFICULT TO ACCEPT SYMPATHY					
DIFFICULT TO EXPRESS JOY					
EVER CONSIDERED SUICIDE					
ANYTHING STILL EFFECTS YOU					
ANYTHING THAT TERRIFIES YOU					
EVER SEEN A PSYCHOLOGIST OR PSYCHIATRIST					
MEN ONLY					
PAIN IN SCROTUM OR TESTICLES					
DISCHARGE/INFECTION FROM PENIS					
PREMATURE EJACULATION					
INABILITY TO GET ERECTION					
NOCTURNAL EMISSION (WETDREAM)					
PROSTATITIS					

YOUR HEALTH HISTORY

NAME: _____

CONCERN, DISEASE, ILLNESS OR ACCIDENT	YES OR ALWAYS	SOME-TIMES	NEVER	SINCE WHEN	DETAILS YOU THINK WE MAY NEED TO KNOW
WOMEN ONLY (Please answer even if you no longer have periods.)					
IRREGULAR OR ABSENT MENSTRUATION					
PAINFUL MENSTRUATION					
VERY LIGHT FLOW					
VERY HEAVY FLOW					
CLOTS PASSED WITH THE FLOW					
BLEEDING AFTER INTERCOURSE					
BLOATED BEFORE PERIOD					
BLEEDING BETWEEN PERIODS					
IRRITABLE/MOODY BEFORE PERIOD					
HOT FLASHES					
LOW BACK PAIN WITH PERIODS					
EVER TAKE BIRTH CONTROL PILLS					
ANY ADVERSE EFFECTS FROM PILL					
BREAST TENDERNESS OR SWELLING					
LUMPS IN THE BREAST					
VAGINAL DISCHARGE/ INFECTION					
INFERTILITY					
ANY ABNORMAL PAP SMEARS					
DATE OF LAST PAP SMEAR					
AGE AT FIRST PERIOD					
NUMBER OF DAYS BETWEEN PERIODS					
NUMBER OF DAYS OF FLOW					
DATE OF LAST PERIOD					
NUMBER OF PREGNANCIES					
NUMBER OF LIVE BIRTHS					
NUMBER OF MISCARRIAGES					
NUMBER OF STILLBIRTHS					
NUMBER OF ABORTIONS					
NUMBER OF CESAERIANS					
BIRTH CONTROL METHOD					

YOUR HEALTH HISTORY

NAME: _____

WOMEN AND MEN BOTH PLEASE ANSWER THE QUESTIONS BELOW

PLEASE LIST MAJOR STRESSORS IN YOUR LIFE?

_____

_____

_____

WHAT MAKES YOU FEEL BETTER OR WORSE?

_____

_____

_____

PLEASE LIST YOUR MAIN HEALTH CONCERNS.

_____

_____

_____

DO YOU HAVE ANY OTHER WELL-BEING CONCERNS?

_____

_____

_____

WHAT IN YOUR ENVIRONMENT MAKES YOUR CONCERN(S) BETTER OR WORSE?

_____

_____

_____

PLEASE MAKE A LIST OF WELL-BEING GOALS YOU NEED TO ACHIEVE.

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