HEALTH HISTORY QUESTIONNAIRE

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: _____/_____/_____ Age: _____ Date of Birth: _____/_____/_____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: _(_____)_____Work Phone:_(_____)_____

Cell: Phone: ( ) E-Mail: _____

Preferred Contact Method: _____ Marital Status: ☐M ☐DP ☐S ☐D ☐ W

May we email or mail you periodically (newsletter, reminders, birthday card, specials etc)? Yes No

In Case of Emergency, Contact:_____ Phone No.: _____

Guardian (if under 18): _____

Gender: ☐M ☐F Height: ____'____" Weight: _____lbs. Soc. Sec. #: _____-_____-_____

Occupation:_____Employer:_____

How did you hear about our office? _____

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

	Complaint	How long?	Cause or Diagnosis
1			
2			
3			
4			

How do these conditions impair your daily activities?_____

II. Patient Medical History

Childhood illnesses:_____ __

Surgeries:_____

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

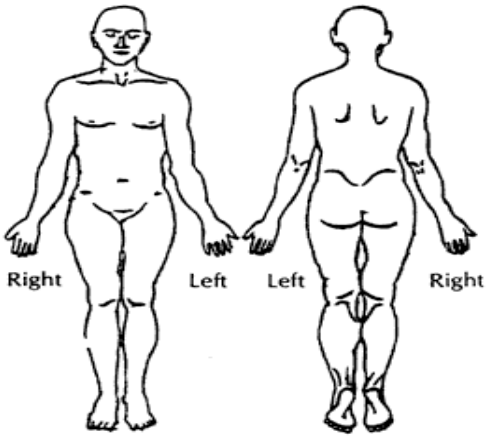
☐other:_____

Medications and supplements (list all medications and/or supplements you currently take or have taken in the last 6 months):

Medication	Dosage	Date of last dose

III. Patient Profile

Please clearly mark any areas of pain:



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:

Chills & Fever / Sweating	Ears / Eyes	Sleep / Pain Quality
Chills & Fever ☐Simultaneously fever w/aversion to cold ☐Chills >fever ☐Fever>Chills ☐Alternating chills/fever ☐Chills w/shivering ☐Low grade fever worse at night ☐Constant low grade fever ☐Fever middle of night in adults ☐Fever in the middle of the night (child) **Sweating** ☐Sweating ☐No Sweating **Area of Body** ☐Only on Head ☐Oily sweat forehead ☐Arm/Legs ☐Hands ☐Whole body ☐On palms, soles, chest (5 palm heat) **Time of Day** ☐Day time ☐Night time **Condition of disease** ☐Profuse cold sweat ☐Oily sweat forehead like pearls **Quality of sweat** ☐Oily ☐Yellow	**Ears:** **Tinnitus** ***Onset*** ☐Sudden onset ☐Gradual ***Pressure*** ☐Noise worse with hands over ears ☐Noise better with hands over ears ***Noise*** ☐Loud, high pitch, whistle ☐Low pitch, like rushing water **Deafness** ☐Sudden ☐Gradual ☐Chronic **Eyes** **Pain** ☐Like a needle w/redness ☐W/redness, swelling ☐Blurred vision, floaters ☐Photophobia ☐Feeling pressure ☐**Dryness**	**Insomnia** – focus on Blood and Yin ☐Hard falling asleep once asleep fine ☐Waking many time during night ☐Dream Disturbed ☐Restless sleep w/dreams ☐Waking early am and falling asleep again **Lethargy** ☐Sleepy after eating ☐General heaviness ☐W/heaviness and dizziness ☐Extreme lethary, lassitude and cold ☐Lethargic stupor w/exterior Heat ☐Letharic stupor w/rattling in throat **Pain Quality** ☐Pain relieved by pressure ☐Relieved by Cold ☐Relieved by Heat ☐Stabbing, fixed pain ☐Fixed pain ☐Migrating pain ☐Numbness, soreness ☐Heaviness

Head & Body

Headache

Onset

☐Recent, short duration ☐Gradual

Time of Day

☐Daytime ☐Night time

Location

☐Nape of neck/Occipital

☐Forehead ☐Temples

☐Vertex ☐Whole Head

Character of Pain

☐Heaviness ☐Pain inside head

☐Distending, throbbing

☐Boring, small point

Condition

☐Aversion Wind and/or Cold

☐Worse w/Cold ☐Worse with Heat

☐Worse with fatigue

Dizziness

☐Severe giddiness w/loss of balance

☐Slight dizziness w/ heaviness

☐Slight Dizziness when tired

☐Sudden onset ☐Gradual onset

☐Spinning ☐Loss of balance

☐Feels heavy

Pain in Body

Whole body

☐Sudden ☐All over w/tired

☐Muscles w/heat sensation

☐Pain w/heaviness

Joints

☐Wandering ☐Fixed

☐Fixed w/swelling, numbness

Backache

☐Dull, continuous

☐Acute, severe, stiff

☐Severe worse damp & cold

☐Pain in back extending to shoulder

Numbness

☐Arms/legs or Bilateral hands/feet

☐Unilateral fingers/elbows

Thorax and Abdomen / Food & Taste / Thirst & Drink

Location

☐Thorax ☐Flanks ☐Abdomen

Pain

☐Chest ☐Chest pain w/cough

☐***Hypochondriac pain***, distention

☐Severe pain

☐***Epigastric pain***

☐Dull pain ☐Fullness

☐Alleviated by eating

☐Aggravated by eating

☐***Lower abdominal pain***

☐Worse with bowel movement (BM)

☐Better with bowel movement (BM)

☐***Hypogastric pain***

Food & Taste

Taste

☐Bitter

☐LV

☐HT

☐Sweet ☐Sour ☐Salty ☐Pungent

Food

Vomiting

☐Sour

☐Bitter

☐Clear watery

☐Soon after eating

☐Sudden w/ loud noise

☐Slow w/ weak noise

Thirst & Drink

☐Drink large amounts cold

☐Absence

☐Thirst no desire to drink

☐Sip slowly or warm liquids

☐Cold liquids

☐Warm liquids

Stool / Urine / Leucorrhea

Constipation

☐Worse after bowel movement

☐Better after bowel movement

☐Acute, dry, yellow

☐Old individual or after child birth

☐Small bitty pieces

☐Not dry w/difficulty BM

☐W/abdominal pain

☐Dry with no thirst

☐Alt constipation/Diarrhea

Diarrhea

☐With pain ☐W/Foul smell

☐No smell

☐Chronic qEarly AM (cocks crow)

☐With abdominal pain

☐With mucus

☐With mucus and Blood

☐Loose with undigested food

☐Burning anus

Urine

Function

☐Enuresis ☐Retention

☐Difficulty ☐Frequent/copious

☐Frequent/Scanty

Pain

☐Pain before ☐During ☐After

Color

☐Pale ☐Dark ☐Turbid/Cloudy

☐Copious, clear, pale during exterior invasion

Amount

☐Large ☐Small

Women only (Men should complete the next section):

Date of last menstrual period? ____/____/____

Regular menstrual cycle? ☐Y ☐N

Pregnant? ☐Y ☐N

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:_____

☐Vaginal discharge

☐Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐nausea ☐vomiting ☐water retention ☐breast swelling

☐food cravings ☐headaches ☐migraines ☐breast tenderness

☐depression ☐irritability ☐anxiety ☐other emotions:_____

☐dull pain, where?_____ ☐sharp pain, where?_____

If you are being seen for fertility or menstrual issues, please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, 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_____

IV. Exercise, Stress and Diet

Exercise: ☐10-30 min ☐60 min ☐90 min > Type/s of exercise:_____

How many days a week: ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐ 7days

Stress level (scale I – 10) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10+
Lowest ***Highest***

Food Intake: Typical eating habits

	Morning	Noon	Evening
List what food you typically eat for different meals. If you eat smaller meals 5-6 times a day add then in.			
Quality of Food			
How much water do you drink a day			

FRAME	☐I am thin, lanky and slender with prominent joints and thin muscles.	☐I have a medium, symmetrical build with good muscle development.	☐I have a large, round or stocky build. My frame is broad, stout or thick,
WEIGHT	☐Low; I may forget to eat or have a tendency to loose weight.	☐Moderate; it is easy for me to gain or lose weight if I put my mind to it.	☐Heavy; I gain weight easily and have difficulty losing it.
EYES	☐My eyes are small and active.	☐I have a penetrating gaze.	☐I have large pleasant eyes.
COMPLEXION	☐My skin is dry, rough or thin.	☐My skin is warm, reddish in color and prone to irritation.	☐My skin is thick, moist and smooth.
HAIR	☐My hair is dry, brittle or frizzy.	☐My hair is fine with a tendency towards early thinning or graying.	☐I have abundant, thick and oily hair.
JOINTS	☐My joints are thin and prominent and have a tendency to crack.	☐My joints are loose and flexible.	☐My joints are large, well knit and padded.
SLEEP PATTERN	☐I am a light sleeper with a tendency to awaken easily.	☐I am a moderately sound sleeper, usually needing less than eight hours to feel rested.	☐My sleep is deep and long. I tend to awaken slowly in the morning.
BODY TEMPERATURE	☐My hands and feet are usually cold and I prefer warm environments.	☐I am usually warm, regardless of the season, and prefer cooler environments.	☐I am adaptable to most temperatures but do not like cold, wet days.
TEMPERAMENT	☐I am lively and enthusiastic by nature. I like to change.	☐I am purposeful and intense. I like to convince.	☐I am easy going and accepting. I like to support.
UNDER STRESS	☐I become anxious and/or worried.	☐I become irritable and/or aggressive.	☐I become withdrawn and/or reclusive.

Patient Signature:_____