# HEALTHY HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held **absolutely confidential.** If you have any questions, please ask. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments section. **Thanks!**

Name: _____ Phone: _____Cell:_____
Address:_____ City: _____ State: _____ Zip: _____
Email Address: _____
Date of Birth: _____ Place of Birth: _____ Marital Status:_____

Employer: _____ Occupation: _____
Family Physician: _____ Referred by: _____
In Emergency Contact (name): _____ Emergency Phone: _____
Preferred Method of Contact: Phone _____ Cell _____ Email _____

Have you ever been treated with Acupuncture? Y ___ N ___ Herbal Medicine Y ___ N ___

Main Problem(s) you would like help with: _____
_____

How long ago did this problem begin? _____
_____

How does this problem interfere with your daily activities (work, sleep, sex):
_____
_____

Have you been given a diagnosis for this problem? If so, what: _____
_____

What kinds of treatment have you tried: _____
_____

Your past medical history (please include date): Cancer _____ Diabetes _____
Hepatitis _____ High Blood Pressure _____ Heart Disease/Attack_____
Rheumatic Fever _____ Thyroid Disease _____ Seizures _____
Venereal Disease _____ Stroke _____ Other_____

Surgeries (type and date): _____
_____

Significant Trauma (auto accidents, falls, etc.): _____
_____

Your birth history (prolonged labor, forceps deliver, etc.) _____
_____

Allergies (drugs, chemicals, foods, reaction): _____
_____

Family Medical History (Check): Diabetes ____ Allergies ____ Seizures ____ Heart Disease ___
High Blood Pressure ____ Stroke ____ Asthma ____ Cancer ____
Other _____
Are you currently taking any steroids? Yes ___ No ___
Medications taken within the last two months (drugs, herbs, vitamins, etc):
_____
_____

Do you have a regular exercise program? Yes ___ No ___ Please describe: _____
_____

Have you ever been on a restricted diet? Yes ___ No ___ What kind? _____
_____

Are you currently pregnant? Yes ___ No ____

PLEASE DESCRIBE YOUR AVERAGE DAILY DIET
Morning: _____
Afternoon: _____
Evening: _____
How many packs of cigarettes do you smoke per day? _____
How much coffee, tea, or cola do you drink per week? _____
How much alcohol do you drink per week? _____

## PLEASE CHECK ANY YOU HAVE HAD IN THE LAST 3 MONTHS

### GENERAL
___Chills
___Fevers
___Sweat easily
___Night sweats
___Cravings
___Change in appetite
___Weight gain
___Weight loss
___Poor sleeping
___General fatigue
___Sudden drop of energy

### SKIN AND HAIR
___Rashes
___Itching
___Change in hair or skin
___Eczema
___Oozing on skin lesion
___Dry skin, nails or hair
___Hives
___Pimples
___Loss of hair
___Dandruff
___Slow wound healing
___Easy bruising
___Chronic Infections
___Other hair or skin problems _____

### RESPIRATORY
___Cough
___Persistent cough
___Asthma/Wheezing
___Shortness of breath
___Frequent common colds
___Pain with a deep breath
___Difficulty breathing when lying down
___Production of phlegm
What color:
_____
___Coughing up blood
___Pneumonia
___Bronchitis
___Pleurisy
___Emphysema
___Tuberculosis

### EARS, NOSE AND THROAT
___Dizziness
___Migraines
___Headaches
When: _____
Where: _____
___Sinus problems
___Hayfever

___Frequent allergies
___Facial pain
___Glasses/contacts
___Poor vision
___Color blindness
___Spots in front of eyes
___Eye pain/strain
___Cataracts
___Glaucoma
___Eye dryness
___Excessive tearing
___Discharge from eyes
___Poor hearing
___Ringing in ears
___Earaches
___Discharge from ear
___Nose bleeds
___Sinus congestion
___Nasal Drainage
___Grinding teeth
___Teeth problems
___TMJ/Jaw problems
___Concussions
___Recurrent sore throats
___Hoarseness
___Sores on lips or tongue
Other head or neck problems

_____
_____

**CARDIOVASCULAR**
___High blood pressure
___Low blood pressure
___Bleed or bruise easily
___Peculiar tastes or smell
___Strong thirst (hot or cold)
___Thirst, no desire to drink
___Fatigue
___Chest discomfort/pain
___Heart palpitations
___Cold hands or feet
___Swelling of hands or feet
___Varicose veins
___Blood clots
___Fainting
___Difficulty breathing
___Pacemaker
Other heart or blood vessel problems:

_____

**GASTROINTESTINAL**
___Bad breath
___Nausea
___Vomiting
___Heartburn
___Belching
___Indigestion
___Stomach ulcers
___Changes in appetite
___Diarrhea
___Irritable bowel syndrome
___Constipation
___Chronic laxative use
___Blood in stools
___Black stools
___Abdominal pain or cramps
___Gas
___Rectal pain
___Hemorrhoids
___Gall Bladder disease
___Gall Bladder stones

**GENITO-URINARY**
___Pain on urination
___Urgency to urinate
___Frequent urination
___Blood in urine
___Decrease in flow
___Unable to hold urine
___Dribbling
___Incontinence
___Kidney stones
___Impotency
___Change in sexual drive
___Sores on genitals
___Frequent UTI
___Edema
___Do you wake to urinate? Yes__ No__
How often?

_____
What is the color of your urine?

_____
___Kidney disease
___Kidney stones

**MUSCULO-SKELETAL**
Check all areas of pain
___Neck
___Shoulder
___Back
___Elbow
___Hand/wrist
___Hip
___Knee
___Foot/ankle
___Osteoporosis/penia
___Muscle spasm/cramps
___Muscle weakness
Other: _____

**NEUROPYSCHOLOGICAL**
___Seizures
___Areas of numbness/tingling
___Weakness
___Sleep disorders/Insomnia
___Concussion
___Vertigo/Dizziness
___Loss of coordination
___Loss of balance
___Poor balance
___Tremors
___Seizures
___Epilepsy
___Paralysis
___Dyslexia
___Poor memory

Other neurological problems?

_____
_____

**EMOTIONAL/MENTAL**

___Anxiety/fear
___Anger/frustration
___Grief/sadness
___Lack of Joy/Mania
___Worry/Over-thinking
___Clinical depression
___Mild depression
___ADD or ADHD
___Panic Attacks
___Bad temper
___Loss of control/violence
___Substance abuse

Have you ever been treated for emotional problems?

_____
Have you ever considered or attempted suicide? Yes ___ No___
If you answered yes are you now? Yes ___ No ___

**OTHER**

___Alzheimer's
___Dementia
___Cancer
Type: _____
___Fibromylagia
___Lupus
___Candida
___Anemia
___Rashes
___Eczema/Hives
___Hemophelia
___Hypothyroid
___Hypoglycemia
___Hyperthyroid
___Diabetes type I
___Diabetes type II
___Significant trauma
Type:_____
___Significant dental work
Type:_____
___Alcoholism
___AIDs/HIV
___Childhood illnesses
___Chicken pox
___Measles
___Mumps

**MEN ONLY**

___Impotence
___Testicular pain/ Redness/Swelling
___Low libido
___Vasectomy
Date: _____
___Seminal emissions
___Excessive libido
___Prostate problems
___Painful intercourse

**PREGNANCY AND GYNECOLOGY**

Are you pregnant now?

___
Trying? _____
Do you practice birth control? Yes ___ No___
What type and how long?

_____

___Number of pregnancies
___Number of births
___Premature births
___Miscarriages
___Abortions

___Age at first menses
_____First date of last menses
___Period between menses
___Duration
___Unusual character (heavy/light)
___Painful periods
___Irregular periods
___Infertility
___Changes in body/psyche prior to menses
___Inter-cycle bleeding
___Clots
___Menopause: Age: _____years
___Hysterectomy?
___Vaginal discharge
___Post-coital bleeding
___Vaginal sores
___Last pap
___Breast lumps
___Nipple discharge
___Breast tenderness
___Fibroids
___Ovarian cysts
___Abnormal pap smear
___Endometriosis
___Painful intercourse
___PMS
___Moodiness
___Painful intercourse
___Change of libido