

Health History & Current Health Questionnaire

Please attempt to fill this form out as thoroughly as possible. Even though some of the questions may seem irrelevant to the condition you are seeking treatment for it may play a role in diagnosis and treatment. All the information you provide to your practitioner is strictly confidential.

General Patient Information

Date: _____

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Marital Status: _____ Height: _____ Weight: _____

Partner/Spouse's Name: _____ Years Married: _____

Children: _____

Pets: _____

Occupations: _____ Employer: _____

Medical History:

Major Complaints in order of significance to you:

	Severe	Moderate	Slight	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these impair your daily activities? _____

What treatments have you tried for these conditions? _____

What result have you seen? _____

How was your health as a child? _____

Immunizations: _____

Surgeries/Hospitalizations: _____

Scars:

Trauma (physical or emotional): _____

Recent Tests: (please indicate test results and date below to those that apply)

Physical Cholesterol Other blood work (_____)

HIV/STD Pap smear Mammography Prostate

Test Results & Date: _____

Circle any that you have had in the past:

Allergies	Epilepsy	Cancer
Allergies	Paralysis	Glaucoma
Bronchitis	Stoke	Lupus
Pneumonia	Migraines	Scleroderma
Emphysema	Vein Condition	Ulcerative Colitis
Diabetes	Multiple Sclerosis	Crohns Disease
Thyroid Disorder	Parkinsons	Kidney Stones
Heart Disease	Fibromyalgia	Gall Stones
Hypertension	Measles	Other neurologic disorder
Hepatitis	Mumps	Other hormone disorder
Pancreatitis	Mononucleosis	Other kidney disorder
Meningitis	Chicken Pox	Other lung disorder
HIV	Polio	Other liver disorder
Syphilis	Tuberculosis	Other pancreas/spleen disorder
Gonorrhea	Rheumatic Fever	Other

Family History:

	Age	Alive	Deceased	Health History
Father	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Profile

Please circle any areas of pain or scars:

Is the pain:

Sharp Cramping Aching
Dull Moving Tingling
Burning Other _____

Do the following lessen the pain?:

Pressure Heat Cold
Exercise Rest Other _____

Do the following worsen the pain?:

Pressure Heat Cold
Exercise Rest Other _____

Overall Energy (Lung, Kidney function):

- Fatigue during the day
- General weakness
- Easily catch colds
- Shortness of breath
- Feel worse after exercise
- Prolonged recovery from illness
- Aversion to talking
- Pasty, pale complexion
- Exercise: What _____ How Often _____

Overall Temperature (Kidney function)

- Cold hands/feet
- Sweaty hands/feet
- Feel generally more Hot
- Feel generally more Cold
- Afternoon flushes
- Red cheeks at times
- Hot flashes any time of day
- Night sweats
- Heat in hands, feet or chest
- Thirsty and drinks in gulps
- Thirsty but no desire to drink
- Thirst but take sips
- Take water to bed
- Perspire easily? Where _____
- Perspire w/ rest
- Lack of perspiration

Spleen function:

- Low appetite
- Abrupt/surprising weight gain
- Abrupt/surprising weight loss
- Abdominal bloating

Heart function:

- Palpitations
- Anxiety
- Panic attacks
- Emotional sensitivity
- Restlessness
- Easily startled
- Trouble falling asleep
- Dull or glazed eyes
- Chest pain or discomfort
- Sores on tip of the tongue
- Frequent dreams
- ever fainted

Lung function:

- Nasal discharge, Color _____
- Sinus congestion
- Allergies, To: _____
- Nose bleeds
- Dry cough
- Productive cough, Color _____
- Dry mouth, nose, throat, skin
- Sore throat
- Overall achy feeling
- Alternating chills and fever
- Trouble breathing
- Asthma – trouble w/ exhaling
- Sadness, melancholy, grief

Stomach function:

- Large appetite
- Mouth (canker) sores
- Bad breath
- Bleeding, swollen, painful gums

- Abdominal gas
- Gurgling noise in stomach
- Fatigue after eating
- Prolapsed organs (bladder, uterus, etc.)
- Hernias
- Hemorrhoids
- Easily bruised
- Pensive
- Over-thinking, obsess
- Worry
- Difficulty focusing, distractible
- Overwhelmed by details

Large and Small Intestine Function:

- Bowel movement (#/day____, or #/wk____)
- Loose
- Diarrhea
- Burning
- Lack of control (incontinence)
- Constipation
- Hard dry stool
- Incomplete
- Blood in stool
- Mucous in stool
- Undigested food in stool
- Cramping or pain
- Gas/flatus
- Blood sugar variable
- Food sensitivity/intolerance: _____

Dampness trapped in the body:

- General sense of heaviness
- Mental heaviness, sluggishness, fogginess
- Swollen hands, feet, joints

- Burning sensation after eating
- Heartburn, acid regurg, GERD
- Ulcer (diagnosed in past)
- Belching
- Hiccoughs
- Stomach pain
- Nausea/Vomiting
- Anorexia
- Bulimia
- Headache on forehead area
- Aversion to strong odors/flavors

Liver/Gall Bladder Function:

- Alternating diarrhea/constipation
- Tight sensation in chest or under ribs
- Bitter taste in mouth
- Lump in throat/trouble swallowing
- Itching
- Skin rashes
- Muscle spasm, twitching or cramping
- Tingling sensation
- Numbness
- Migraines
- Headaches on top or side of head
- Neck and shoulder tension
- Seizures or stroke
- Alcohol (# drinks____/day/week/month)
- Recreational drug history or current use
What: _____
- How often: _____
- Smoke (#cigs__packs____/day/wk)
- Medications: (Name, dosage, for what)

Sexual Function:

- Normal libido
- High libido
- Low libido
- Difficulty with arousal or climax

Men Only:

- Premature ejaculation
- Impotence
- Swollen testicles
- Testicular pain
- Feeling of coldness in genitals
- Prostate swelling or prostatitis
- Elevated PSH

Kidney and Bladder Function:

- Kidney stones
- Urinary tract infections (UTI)
- Wake during the night to urinate
- Low back pain
- Cold knees
- Weak, sore knees
- Frequent cavities
- Broken bones
- Memory problems
- Excess hair loss
- Early graying of hair
- Decrease range of motion
- Repeat miscarriage
- Need excessive sleep
- Apathy or decreased motivation
- Easily defeated or disgruntled
- Dark circle under eyes
- Asthma with trouble inhaling
- Phobia or fears
- Low-pitched ringing in ears

Liver Function (cont'd):

- Eyes bloodshot, hot, dry, painful, gritty
- Watery eyes
- Discharge from eyes
- Conjunctivitis
- Blurred vision
- Decreased night vision
- Cataracts
- Macular degeneration
- Glasses (what age_____)
- Anger easily
- Frustration, irritability
- Depression
- Unable to adapt to stress
- PMS
- High pitched ringing in ears

Blood (liver, spleen, heart function):

- Dizziness, light headed
- See floating spots
- Weak vision
- Dry eyes
- Thin hair
- Pale sallow complexion
- Restless fatigue
- Anxious sleep
- Emotional sensitivity
- Itchy skin
- Muscle cramps
- Dry hard stool
- Anemia
- Infertility
- Lack of semen
- Miscarriage history
- Lack of breast milk
- Postpartum weakness

- Hearing loss or hearing trouble
- Urgency or frequent urination
- Difficult or incomplete urination
- Lack of bladder control
- Stress incontinence
- Crave caffeine & stimulants
- # cups coffee/day ____ or week ____
- Water intake: # glasses/day ____
- Postpartum depression
- Poor skin healing
- Decrease flexibility
- Poor concentration

Women only:

- Regular menses? Y N
 - Pregnant? Y N
 - Number of pregnancies: _____
 - Number of miscarriages/abortions: _____
 - Age of first menses: _____
 - Number of Days of flow: _____
 - Number of Days of entire cycle: _____
 - Bleeding between periods
 - Endometriosis Ovarian Cysts
 - Complications with pregnancies: _____
 - Birth Control method: _____
 - Do you have any PMS symptoms?
 - Nausea Vomiting Food cravings
 - Headaches Migraines Bloating
 - Breast tenderness Breast swelling
 - Irritability Depression Anxiety
 - Cramping Other: _____
 - Vaginal discharge (color: _____)
 - Fibroids
-
- Vaginal delivery (#: _____) C-sections (#: _____) Breastfed
 - Postpartum complications: _____

Please fill in following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (red, bright, pale, brown, rust, purple)							
Amount (heavy, mod, light, spotting)							
Pain/cramps (dull, sharp)							
Clots (lrg, sml, red, black)							
Vomiting/Nausea							
Headache/Migraine							
Other							