Health History Questionnaire

(Please Print)

This is a **CONFIDENTIAL** questionnaire to help determine the best treatment plan for you. If you have any question, please ask.

Personal Information

Today's Date ____/____/___

Patient's Last Name First Middle Mr. Miss Mrs. Ms. Marital Status (Check One): Single/Married Divorced/ Separated/ Widowed/ Partnered

Is this your legal name? Yes No If not, what is your legal name? (Former Name) Birth Date / / Age Sex M F

Height_____ Weight _____

Address Home Phone No. (___)_____

City State Zip Cellular Phone No. (___)_____

Occupation Employer Employer Phone No. (___)_____

Person Responsible for Account Address (if different) Home Phone No.

Emergency Contact: Name _____ Phone _____

Referred by (Please check one box) Dr._____ Web _____
Family/Friend _____ Sierra Scoop Other_____

Would you like to receive our Email newsletter? Yes No Email Address:

Health Information

Have you received acupuncture therapy before? Yes No When? _____With Whom? _____

List any medications and nutritional supplements (including Herbs) you are currently taking: (Continue on back if necessary)

Medicine Dosage Reason How long Prescribed by

_____

_____

_____

What are the main health concerns for which you are seeking treatment?

_____

_____

List any other health problems you now have.

_____

_____

List any accidents, surgeries, or hospitalizations

_____

_____

List any medications or foods you are allergic to:

_____

_____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer			_____	Diabetes			_____
Hepatitis			_____	Heart Disease			_____
High Blood Pressure			_____	Seizures			_____
Rheumatic Fever disorders			_____	Emotional			_____
Infectious Diseases			_____	Tuberculosis			_____

Sexually Transmitted Diseases: Gonorrhea Syphillis HIV HPV Chlamydia Herpes

Check the Box if any of the following statements are true:

- □ I am taking Coumadin/Warfarin
- □ I have a pacemaker
- □ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

OB/GYN History

Age of 1st period (menarche) _____
Age of last period (menopause) _____
Number of days between periods _____
Number of days of flow _____
Color of flow: normal bright red pale dark rust brown purple other
Clots? Yes No Color _____

Are you pregnant? Yes No # of pregnancies _____
# of live births _____ # of Abortions _____ # Miscarriages _____
Date of last: Gynecologic exam _____ Pap Smear _____
Mammogram _____ Bone Density Scan _____
Results _____
_____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID
Location of Pain: Lower abdomen Lower back Thighs Other _____
Nature of Pain (please indicate before, during and after menses)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other Symptoms related to menses:

Discharge Vaginal dryness Headache
Nausea Constipation Diarrhea
Swollen Breasts Mood swings Insomnia
Ravenous appetite Poor appetite Hot flashes
Increased libido Decreased libido Night Sweats

Urogenital History

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____
Lab results _____
Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky odor: _____
Symptoms related to prostate

prostate problems Delayed stream Post void dribbling Incontinence Retention of Urine
Erectile dysfunction (ed) Increased libido Decreased libido Premature ejaculation
Back pain Groin pain Testicular pain Decreased force of stream
Impotence BPH/Enlarged prostate other _____

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows: leave blank if never experience; √ if sometimes experience; + if frequently experience

— cough
— shortness of breath
— decreased sense of smell

— nasal problems
— skin problems
— feeling of claustrophobia

— bronchitis
— colitis or diverticulitis

— constipation
— hemorrhoids
— recent use of antibiotics
— sadness/grieving
— allergies:_____
— headache
— sore throat
— asthma
— tendency to catch colds

— lack of appetite
— excessive appetite
— loose stool or diarrhea
— digestive problems, indigestion
— vomiting
— belching, burping
— heartburn/reflux
— retention of food in the stomach
— tendency to become obsessive in work and relationships…
— easily bruised
— mucous/blood in stool
— frequent canker sores
— mental fogginess
— edema
— nausea
— snoring
— general sensation of heaviness in body
— # of bowel movements per day _____

— insomnia, difficulty sleeping
— heart palpitations
— cold hands and feet
— nightmares
— mentally restless
— laughing for no apparent reason
— angina pains
— abdominal pain
— chest pain
— headaches
— anxiety
— dizziness
— sores on tip of tongue
— sadness

— low back pain
— sciatic pain
— knee problems
— hearing impairment
— ear ringing
— kidney stones
— decreased sex drive
— hair loss
— urinary problems
— fearful
— night sweats
— body temperature sensation hot cold
— frequent or urgent urination
— facial flushing
— hot flashes
— bone problems

— seizures
— eye problems
— jaundice (yellowish eyes/skin)
— difficulty digesting oily foods
— gall stones
— light colored stool
— soft or brittle nails
— easily angered or agitated
— difficulty in making plans or decisions
— spasms or twitching of muscles
— eyes
itchy bloodshot dry
blurry vision floaters
— tightness in chest
— bitter taste in mouth

— frustrated/irritable
— skin rashes

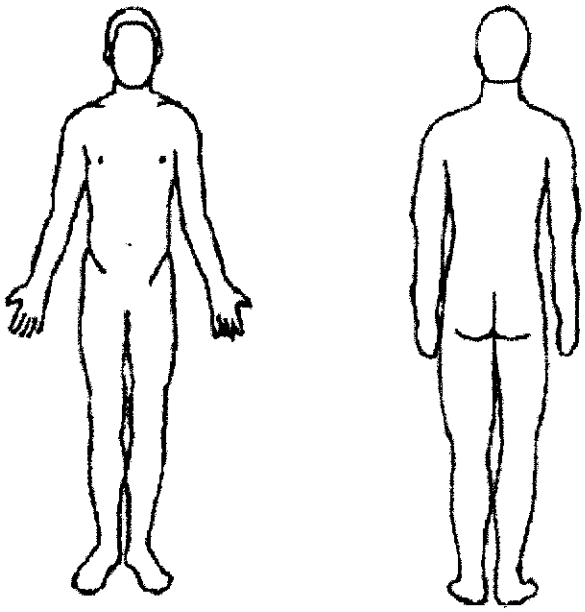
— sensation of lump in throat area
— pain or coldness in genital area

Please clearly mark any areas of pain:

Is the pain: Sharp Burning
Aching Fixed Cramping
Dull Moving
Other: _____

Do the following lessen the pain?
Pressure Cold Heat
Exercise Other: _____

Do the following worsen the pain?
Pressure Cold Heat
Other: _____



Clinical Notes

HPI:

Onset	Location	Duration
Characteristics	Aggravate/alleviate	
Related factors	Treatment	Significance