Health History Questionnaire for Patients

Welcome to our clinic! 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 questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

Last name:_____ First name: _____M.I.:_____

Street address:: _____

City: _____ State: _____ Zip: _____ email: _____

Date of birth: _____ age: _____ Height: _____ Weight: _____Lbs

Home Phone: _____Work Phone: _____

Occupation: _____ Marital Status: _____

Emergency Contact: name: _____Phone:_____

Referred by: _____

Have you tried Acupuncture or Chinese herbal medicine before? _____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

_____

To what extent does this problem affect you daily activities (work, sleep, eating, etc…)?

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? ____yes _____no

If so, what is it? _____

What kinds of treatment have you tried? _____

Comments:_____

_____

_____

PAST MEDICAL HISTORY (If yes, please include dates)

___Allergies_____ ___ Rheumatic Fever_____

___ Cancer_____ ___ Surgeries_____

___Diabetes_____ ___ Venereal Disease_____

___ Hepatitis_____ ___ Thyroid Disease_____

___ High Blood Pressure_____ ___ Seizures_____

___ Birth Trauma (prolonged Labor, forceps delivery, etc…) _____

___ Other significant illness (describe) _____

___ Accidents or Significant Trauma (describe) _____

OTHER RELEVANT MEDICAL HISTORY _____

_____

FAMILY MEDICAL HISTORY

___ Allergies _____ ___ Cancer _____ ___ Seizures _____

___ Diabetes _____ ___ Heart disease _____ ___ Stroke _____

___ Asthma _____ ___ High Blood Pressure _____ ___ Other _____

OCCUPATION

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE

Do you follow a regular exercise program? _____If so, please describe:_____

Please describe your average daily diet: _____

Please check any of the following habits that apply. How much and how often do you use them?

___ Cigarette Smoking _____ ___ Coffee, tea, or cola _____
___ Alcoholic beverages _____ ___ Other: _____

List any medications taken within the last two months (vitamins, drugs, herbs, etc…):

_____

Please describe any use of drugs for non – medical purposes: _____