

TO THE POINT ACUPUNCTURE

HEALTH HISTORY QUESTIONNAIRE

Please take the time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

NAME: _____ DATE: _____
ADDRESS (include street, apt. #, city, state, zip) _____

EMAIL: _____ DOB: _____
HOME PHONE: _____ WORK: _____ CELL: _____
AGE: _____ HEIGHT: _____ WEIGHT _____ OCCUPATION: _____

FAMILY PHYSICIAN: _____ HEALTH INSURANCE COMPANY: _____
EMERGENCY CONTACT (name, phone number, and relation to you – please list guardian if under 18) _____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

MAIN PROBLEM:

What has brought you to *To The Point Acupuncture*?

Please include: To what extent this problem interferes with daily activities; How long ago this problem began; Diagnosis (if any) given for this problem; and other treatment you have tried.

PATIENT MEDICAL HISTORY:

How was your childhood health? _____

RECENT TESTS:

Physical Cholesterol Mammography Pap Smear
 Blood HIV/STD Prostate Other: _____

Test results and dates: _____

PAST MEDICAL HISTORY: (please check all applicable)

Allergies HIV STD Tuberculosis Cancer
 Bleeding Tendency Pneumonia Glaucoma Diabetes Epilepsy
 Polio Chicken Pox Measles Mumps Rubella
 Hepatitis Multiple Sclerosis Jaundice Rheumatic fever Seizures
 High Blood Pressure Mononucleosis Heart disease High Cholesterol Migraines
 Thyroid disease Kidney stones Gallbladder stones

FAMILY MEDICAL HISTORY:

High Blood Pressure Heart Disease High Cholesterol Stroke Cancer
 Diabetes Seizures Asthma Allergies Other: _____

Current Medications (please include any herbs or supplements you are taking):

Allergies (drugs, chemicals, foods)

Please list any Surgeries/Significant Trauma:

Caffeine (intake per day): _____ **Water** (intake per day): _____
Smoking (# of packs/day): _____ **Alcohol** (# of drinks daily): _____ **Recreational Drugs:** (Y / N): _____

GENERAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Strong thirst (hot or cold drinks) |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Fatigue | |

OVERALL TEMPERATURE:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temp. (sensation) | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temp. (sensation) | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Heat in hands, feet, chest | <input type="checkbox"/> Hot flashes (anytime of day) |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Lack of perspiration |

SKIN & HAIR

- | | | | |
|---|---------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Oily | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Hives | |
| <input type="checkbox"/> Change in hair or skin texture? | | | |
| <input type="checkbox"/> Any other hair or skin problems: _____ | | | |

HEAD, EYES, EARS, NOSE, and THROAT:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Floaters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Tearing/Dryness | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> TMJ/Jaw Problems | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Concussions | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Migraines | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Sores on lips/tongue | | |
| <input type="checkbox"/> Any other face or head problems: _____ | | | |

CARDIOVASCULAR:

- | | | |
|--|--|---|
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Swelling of the feet | <input type="checkbox"/> Swelling of the hands | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Any other heart or blood vessel problems: _____ | | |

RESPIRATORY:

- Frequent Colds
- Persistent Cough
- Difficulty Breathing
- Emphysema
- Asthma
- Shortness of breath
- Bronchitis
- Coughing Blood
- Pain with a deep breath
- Production of phlegm- color?
- Any other lung/breathing problems:_____

GASTROINTESTINAL:

- Ulcers
- Increase/Decrease in Appetite
- Belching
- Passing Gas
- Hemorrhoids
- Abdominal/Epigastric Pain
- Heartburn/Acid Reflux
- Diarrhea
- Constipation
- Abdominal bloating
- Nausea
- Vomiting
- Black stools
- Undigested food in stools
- Blood in stool
- Bad breath
- Bleeding gums
- Rectal pain
- Chronic laxative use
- How often do you have a bowel movement?_____
- Any other problems with your stomach or intestines:_____

URINARY:

- Pain upon urination
 - Frequent urination
 - Blood in urine
 - Urgency to urinate
 - Unable to hold urine
 - Kidney stones
 - Decrease in flow
 - Frequent UTI
 - Incontinence
 - Cloudy urine
 - Scanty urination
 - Profuse urination
 - Does your urine have a strong odor?_____
 - Do you wake to urinate? How often?_____
 - Any other problems with your urinary system:_____
- Color of urine:_____

Libido: High Normal Low

MALE REPRODUCTIVE:

- Erectile Dysfunction
- Prostate Problems
- Testicular Pain/Swelling
- Impotence
- Premature ejaculation
- Cold/numbness in external genitals
- Any other problems with your reproductive system:_____

FEMALE REPRODUCTIVE:

- Are you pregnant?_____ Is it possible you are pregnant?_____ Pregnancies#_____
- Live Births#_____ Premature births#_____ Miscarriages#_____ Abortions#_____
- Age of first menses _____ Duration of menses _____ Time between menses_____
- Last PAP:_____ Birth control? What type and for how long_____

MENSTRUAL CYCLE:

- Light Flow
- Medium Flow
- Heavy Flow
- Clotting
- Irregular Cycles
- Painful Periods
- Bleeding between periods
- Spotting
- Color of the blood:_____
- Cysts
- Endometriosis
- Polyps
- PMS (please describe):_____
- Difficulty Conceiving
- Breast Lumps
- Vaginal Discharge - Color:_____

MENOPAUSE:

- Menopause Age:_____ Menopausal Symptoms (please describe):_____
- Any other problems with your reproductive system:_____

MUSCULOSKELETAL:

- Neck pain
- Mid Back Pain
- Leg Pain
- Joint Pain (location): _____
- Shoulder Pain
- Low Back Pain
- Hand/wrist Pain
- Upper Back Pain
- Arm Pain
- Foot/ankle Pain

QUALITY OF PAIN:

- Sharp
- Moving
- Dull
- Achy
- Burning
- Cramping
- Fixed
- Other: _____

WHAT MAKES THE PAIN BETTER:

- Pressure
- Heat
- Cold
- Exercise
- Other: _____

WHAT MAKES THE PAIN WORSE:

- Pressure
- Heat
- Cold
- Exercise
- Other: _____

Does weather affect the pain: Type of weather: _____

Any other muscle, joint, or bone problems: _____

NEUROLOGICAL:

- Stroke
- Loss of Balance
- Poor Memory
- Any other neurological problems: _____
- Paralysis
- Seizures/Epilepsy
- Numbness/Tingling
- Dizziness

EMOTIONAL/PSYCHOLOGICAL:

- Anxiety
- Over-thinker/worry
- Have you ever been treated for emotional problems: _____
- Have you ever attempted or considered suicide: _____
- Any other emotional issues: _____
- Depression
- Grief/sadness
- Bad Temper/irritable
- Fear
- Easily susceptible to stress

Comments:

Please let me know of any other problems you would like to discuss
