Health History Questionnaire

Green Point Acupuncture L.L.C.

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 there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments Section on page 4. Thank you.

Patient Personal Information **Date: ____/____/______**

Name:			Social Security Number:		
Address (Street Number and Name):			City:	State:	Zip Code:
Home Phone:		Cell Phone:		Gender ________Male ________Female	
Date of Birth (mm/dd/yyyy):			E-Mail Address:		
Height:	Weight:	Ethnic Background _____Caucasian/White _____African American/Black _____Asian/Pacific Island _____American Indian/Alaska Native Hispanic (any race) Other, please specify			
Employer Name:					
Occupation:		Martial Status ___Never Married ___Separated ___Divorced ___Married ___Living with Partner ___Widowed			
Family Physician: Physician's Phone:		Education (mark the highest level achieved) ___Grade School or less ___High School Graduate ___Vocation or Technical School ___Graduate of Professional School ___College Graduates			
Referred By:					

Emergency Contact

Name:	Relationship:	Phone number:
Address:		

Chief complaints

What is/are the main problem(s) you would like us to help you with:

1)____

2)____

3)____

Present Illness

How long ago did this problem begin (be specific)? ____________________________________

To what extent 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? ____

____

Past Medical History

Cancer ___	High Blood Pressure ___	Thyroid Disease ___
Diabetes ___	Heart Disease ___	Seizures ___
Hepatitis ___	Rheumatic Fever ___	Venereal Disease ___
HIV ___	Other ________	

Surgeries (type of and date): ____

____

Significant Trauma (auto accidents, falls etc): ____

____

Your Birth History (prolonged labor, forceps delivery, etc): ______________________________

____

Allergies (drugs, chemicals, food/results): ____

____

Family Medical History (check)

☐ Diabetes	☐ High Blood Pressure	☐ Stroke	☐ Asthma
☐ Cancer	☐ Heart Disease	☐ Seizure	☐ Allergies
☐ Other ________________________________			

Medical take within the last two months (vitamins, drugs, herbs, etc) ______________________________

____

____

Occupational Stress (chemical, physical, psychological, etc) ______________________________________

____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe __________________________

____

Have you ever been on a restricted diet? ☐ Yes ☐ No What kind? _____________________________

____

Do you smoke? ☐ Yes ☐ No 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 describe any use of drugs for non-medical purposes: _____________________________________

____

Please Check Any Symptoms You Have Had in the Last Three Months

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  Time of day _______
- ☐ Edema
  Where ___________
- ☐ Poor Sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weigh gain
- ☐ Weigh lose

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing on skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems _________

____

Head, Eye, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches

  When___________

  Where ___________
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision

☐ Color blindness
☐ Blind field
☐ Sports in front of eyes
☐ Eye pain
☐ Eye strain
☐ Cataracts
☐ Eye dryness
☐ Excessive tear
☐ Discharge from eyes
☐ Poor hearing
☐ Ringing in ears
☐ Earaches
☐ Discharge from ear
☐ Nose bleeds
☐ Sinus congestion
☐ Nasal drainage
☐ Grinding teeth
☐ Teeth problems
☐ Jaw clicks
☐ Concussions
☐ Recurrent sore throats
☐ Hoarseness
☐ Sores on lips or tongue

Other head or neck problems

____

____

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Chest discomfort/pain
☐ Heart palpitation
☐ Cold hands or feet
☐ Swelling of hands
☐ Blood clots
☐ Fainting
☐ Difficulty in breathing

Other heart or blood vessel problems

____

____

Respiratory

☐ Cough
☐ Asthma/Wheezing
☐ Pain with a deep breath
☐ Difficulty in breathing when lying down
☐ Production of phlegm. What color_____
☐ Coughing blood
☐ Pneumonia
☐ Bronchitis

Other lung problems

____

____

Gastrointestinal

☐ Bad breath
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Belching
☐ Indigestion
☐ Diarrhea
☐ Constipation
☐ Chronic laxative use
☐ Blood in Stools
☐ Black stools
☐ Abdominal pain or cramps
☐ Gas
☐ Rectal pain
☐ Hemorrhoids

Other stomach or intestinal problems

____

____

Genito-Urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Blood in urine
☐ Decrease in flow
☐ Unable to hold urine
☐ Dribbling
☐ Kidney stones
☐ Impotency
☐ Chang of sexual drive
☐ Sores on genitals
☐ Wake up to urinate. How often____________
☐ Any particular color to your urine__________

Other genital or urinary system problems ____

____

Pregnancy and Gynecology

☐ Number of pregnancies ______
☐ Number of births ___
☐ Number of premature births ___
☐ Number of miscarriages ______
☐ Number of abortions ______
☐ Age at first menses __
☐ Period between menses (days) ___
☐ Duration of menses (days) ____
☐ First date of last menses ____/____/_____
☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation
☐ Clots
☐ Menopause
Age _________
Year ________
☐ Vaginal discharge
☐ Postcoital bleeding
☐ Vaginal sores
Date of last pap ____/____/_______
☐ Breast lumps
☐ Nipple discharge
☐ Do you practice birth control? ☐ Yes ☐ No
What type and how long

____

____

Musculoskeletal

☐ Neck pain
☐ Shoulder pain
☐ Back pain
☐ Elbow pain
☐ Hand/wrist pain
☐ Hip pain
☐ Knee pain
☐ Foot/ankle pain
☐ Muscle pain
☐ Muscle weakness

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Weakness
☐ Sleep disorder
☐ Concussion
☐ Bad temper
☐ Loss of control /violence potential
☐ Vertigo
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Loss of balance
☐ Poor memory
☐ Anxiety
☐ Substance abuse

Have you been treated for emotional problems?
☐ Yes ☐ No

Have you ever consider or attempted suicide?
☐ Yes ☐ No

Other neurological or psychological problems

____

Please note the degree of severity of your problem now:

Please not the greatest degree of severity of your problem within the last week:

Indicate painful or distressed areas:

Symbols

Pain/pressure	X
Swelling	⌒
Tension	+
Weakness	–
Pulsing	✳
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑

Comments (please tell us any other problems you would like to discuss) ______________________________

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