Today's Date: _____

Acumedicine Health

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Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All answers are confidential. Please ask if you have any questions. If there is anything you wish to bring to our attention, please note it in the comments section. Thank you.

Name: _____ Date of Birth: _____
Home Phone: _____ Mobile Phone: _____
Occupation: _____Work Phone: _____
Marital Status: _____ Height: _____ Weight: _____

Have you tried acupuncture or herbal medicine before? _____

Main problem(s) you would like to address: _____
_____
When did you first notice these symptoms:_____
What extent does this problem affect your daily activities (work, sleep, eating exercise)_____
_____
_____
_____
Has your physician given you a diagnosis? _____ What is the diagnosis: _____
Name of Physician: _____ Phone: _____
What kind of treatment, therapy, or medications have you tried for this problem? _____
_____
_____
Additional Information_____
_____

Past Medical History

_____ Asthma	_____ HIV/AIDS	_____Pacemaker	_____ Port
_____ Cancer	_____ Blood Clots	_____Diabetes	_____ Other
_____ Hypoglycemia	_____ High Blood Pressure	_____High Cholesterol	
_____ Rheumatic fever	_____ Low Blood Pressure	_____Thyroid Disease	
_____ Heart Disease	_____ Phlebitis	_____Seizures	
_____ Hepatitis	_____ GI tumors or polyps	_____Implant	

Accidents or significant trauma _____
Surgeries _____
_____
List location of all scars (surgical and injury)_____
Allergies _____
_____
Vaccination History: Any reactions that you remember or any unusual vaccinations?_____
_____
List medications you have taken in the past six months. Include vitamins, herbs, drugs etc.(even if you take them only occasionally)_____
_____
_____

Family Medical History List family member as: **M**other, **F**ather, **Si**ster, **B**rother, **So**n, **D**aughter. Add **Pa**ternal or **Ma**ternal prefix for **C**ousin, **A**unt, **U**ncle, **G**randparents. List any pertinent information you would like to include.

_____ Alcoholism _____ _____ Diabetes_____
_____ Allergies _____ _____ Heart Disease_____
_____ Asthma _____ _____ Seizures _____
_____ Cancer _____ _____ Stroke_____
_____ Other _____

Number of Children – Please indicate by gender and age: _____

Occupational Stress Factors---Please indicate physical, psychological, chemical stressors: _____
_____

Lifestyle---Have you undergone a major life change in the past year (change in job, marital status, birth, death, move, etc)? Please briefly describe the change _____
_____
Describe your general overall emotional status _____
_____
Describe your primary social relationships/support network_____
Do you follow a regular exercise program?_____ Please describe _____
_____

How many sit-down meals do you have in a day?_____Where?_____
When is your first meal of the day?_____What is it usually?_____
When and what is your last meal of the day?_____
What do you snack on during the day?_____When do you snack?_____
What veggies do you like?_____What veggies do you dislike?_____
What animal protein do you prefer or eat most frequently?_____
What foods do you think you need or should be eating?_____
Cravings:_____Prefer snacks that are: ☐ Sweet ☐ Salty ☐ Crunchy

Please indicate if you use any of the following; include frequency and amount:
Alcohol_____ Cigarettes/Tobacco products_____
Caffeine_____Diet soft drinks_____

Do you generally feel warmer or colder than others?_____What season(s) do you prefer?_____
Are you frequently thirsty?_____ How much water do you drink in a day?_____
What temperature do you prefer your drinks?_____

Sleep---How many hours of sleep do you require?_____ Are you refreshed upon awakening?_____
Do you experience insomnia?_____ Describe the frequency and nature_____
_____

General---Do you experience any of the following? Indicate any **C**urrent problem or symptom with a **C**; use a **P** for items that affected you in the **P**ast.

_____ Bleeding or bruising easily _____ Frequent sighing _____ Poor balance or lack of coordination
_____ Recent changes in weight _____ Tremors _____Fatigue or exhaustion _____Difficulty concentrating on a task
_____ Energetic through evening up to Midnight but hate to wake up early in A.M.

Do you have any areas of numbness or tingling? _____

Skin and Hair

_____ Dry hair _____ Itching _____Acne
_____ Hair loss _____ Psoriasis _____Fungal Infections
_____ Eczema _____ Rashes
_____ Hives _____ Warts

Perspiration (Absent, easily, frequent, night sweats, profuse, on palms of hands and soles of feet)
_____

Head, Eyes, Ears, Nose and Throat

_____ Headaches: Where is the discomfort, forehead, back, top, sides or temple? _____
_____

_____ Dizziness _____ Sinus Pain
_____ Dry eyes _____ Frequent sinus infections
_____ Red eyes _____ Recurrent sore throat
_____ Night blindness _____ Sensation of something stuck in throat
_____ Cataracts _____ Dry nose
_____ Glasses/Contacts _____ Nose bleeds
_____ Spots or floaters _____ Grinding teeth
_____ Earaches _____ Sores on lips, tongue or gums
_____ Ringing in ears _____ Facial Pain
_____ Poor hearing _____ Teeth or gum problems
_____ Chronic sinus drainage _____ Jaw Pain
_____ Migraine headaches with nausea

Comments_____

Cardiovascular

_____ Irregular heart beat _____ Swelling of hands _____Fast pulse (over 100 /minute)
_____ Palpitations _____ Swelling of feet or ankles _____Slow pulse (less than 60 /minute)
_____ Fainting _____ Difficulty breathing _____Red or flushed face
_____ Cold hands or feet _____ Varicose veins

Comments_____

Respiratory

_____ Cough _____ Difficulty breathing when lying down _____ Prone to getting respiratory infections
_____ Phlegm _____ Shortness of breath with daily activity

Comments_____

Gastrointestinal

Describe your appetite (poor, good, excessive, irregular)_____

_____ Abdominal distention _____ Hemorrhoids ____ Ulcer
_____ Bad breath _____ Indigestion/reflux ____ Irritable bowel syndrome
_____ Belching _____ Nausea ____ No appetite for breakfast
_____ Constipation _____ Rectal pain
_____ Diarrhea _____ Taste; sour, bitter, sweet, etc
_____ Gas _____ Vomiting

Abdominal pain or cramps associated with eating?_____
Bowel movements; frequency, consistency, color :_____

Genitourinary

_____ Blood in urine
_____ Frequent urination
_____ Urgency to urinate
_____ Pain on urination
_____ Decrease in urine flow
_____ Inability to empty bladder
_____ Kidney stones
_____ Sores on genitals

Do you easily get bladder infections?_____
Do you wake up at night to urinate?_____ How often?_____
What color is your urine? _____
Does your urine have an odor? _____
Other genital or urinary problems:_____

Reproductive / Gynecologic: Please answer even if you are post-menopausal.

_____ Age of first menses
_____ Length of cycle
_____ Number of pregnancies
_____ Number of live births
_____ Number of C-Sections
_____ Age at menopause
_____ Duration of bleeding /period
_____ Miscarriages
_____ Hot Flashes
_____ Infertility

Menstruation**:** Color_____ Amount _____
Cramps_____ Clots_____
Premenstrual changes-PMS. Mood swings, breast tenderness, bloating, cramps, cravings, etc_____
Are you currently pregnant or planning a pregnancy?_____
Have you ever taken Birth Control Pills?_____How long?_____
Have you been diagnosed or treated for: ☐ fibroids ☐ ovarian cysts ☐ endometriosis
Have you had: ☐ tubal ligation _____(yr) ☐ laproscopic surgery_____(yr)
Do you get vaginal yeast infections easily / frequently?_____

Male reproductive: ☐ vasectomy _____(yr) ☐ impotence ☐ premature ejaculation ☐ infertility
Prostate gland problem:_____

Musculoskeletal: Pain location. Please indicate which side by using **R** for right and **L** for left or **B** for both sides.

_____ Neck
_____ Shoulder
_____ Elbow
_____ Wrist
_____ Hands/Fingers
_____ Upper Back
_____ Mid Back
_____ Lower Back
_____ Pelvis
_____ Hips
_____ Knees
_____ Ankles
_____ Feet/Toes

Describe the problem, nature and quality of the pain, disabilities and the limitations you experience due to this/these problems. _____
_____

Additional information you would like us to be aware of:_____
_____
_____
_____
_____