Winchester Center for Acupuncture & Health

600 Main Street, #4 Winchester MA 01890 781.729.8880

HEALTH HISTORY QUESTIONAIRE

Please fill out this questionnaire to the best of your ability. Your answers will assist us in providing you with a complete evaluation. All answers will be held in absolute confidentiality. If you have any questions, please ask. If there is anything you wish to add that is not included in this questionnaire, please note it in the "Comments" section at the end. Thank you.

Name_____Date_____

Street_____City_____State/Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Email_____

Age_____Date of Birth_____Male____Female____ Height_____Weight_____

Marital Status: Married Never Married Widowed Divorced/Separated

Education: Grammar School High School College Masters Doctorate

Occupation:_____

Emergency Contact: _____Relation to You_____

Emergency Contact telephone:_____

Main condition you would like us to help you with:_____

_____

_____

_____

How long ago did this problem begin and how did it begin?_____

_____

_____

_____

How does it affect your life now?_____

_____

Have you been given a diagnosis for this condition? If yes, by whom and what is the diagnosis?_____

_____

_____

What kind of treatment have you sought for this condition and when ?_____

_____

_____

_____

Is there anything else that you would like us to help you with?_____

_____

_____

_____

Past Personal Medical History of Significant Illness:

□ Asthma □ Allergies □ Hepatitis □ Tuberculosis

□ Diabetes □ Cancer □ Stroke □ Heart disease □ High Blood Pressure

□ Seizures □ Thyroid □ Clotting disorders □ Other:_____

Hospitalizations/Surgeries (include dates):_____

_____

_____

_____

_____

Significant Trauma (accidents, falls, head injuries etc., including dates)_____

_____

_____

_____

Allergies (drugs, food, chemicals, environmental, seasonal):_____

_____

_____

_____

Medications:

Name	Dosage/Frequency	Length of time taken	Reason for taking

What areas of your life are stressful? How does it affect your quality of life?_____

_____

_____

_____

Do you have a regular exercise program? No Yes If yes, please describe:_____

_____

_____

_____

Do you follow any type of special diet (i.e., vegetarian, vegan, medically related, or other)?_____

_____

_____

Do you smoke? _____How much/day_____How long?_____

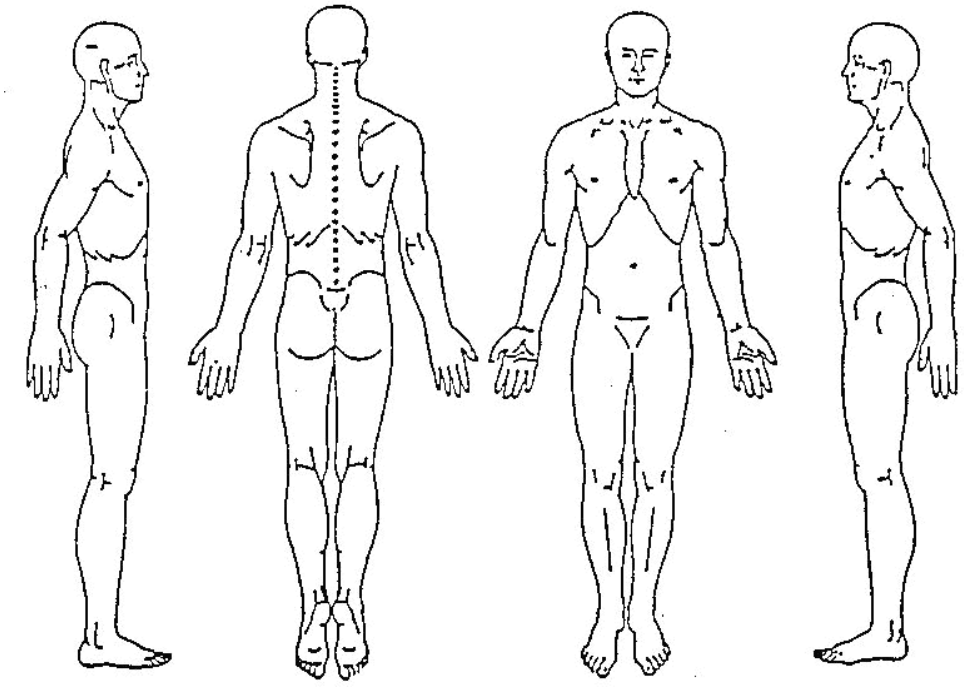
How many cups of caffeinated coffee, tea, or soda do you drink per week?_____

_____

How many glass of 8 oz. water do you drink per day?_____

How many alcoholic beverages do you drink per week?_____

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

GENERAL:

□ Fevers □ Chills □ Fatigue □ Sweat easily or profusely

□ Poor sleeping □ Night sweats □ Unexplained weight loss or weight gain

□ Cravings □ Change in appetite □ Strong thirst for: hot drinks cold drinks

□ Sudden drop in energy, if so what time of day?_____

□ Bleed or bruise easily □ Peculiar tastes or smells □ Lack of taste or smell

SKIN & HAIR

□ Rashes □ Ulcerations □ Hives □ Itching – night or day

□ Eczema □ Pimples □ Dandruff □ Loss of hair

□ Recent moles □ Psoriasis □ Dermatitis □ Acne

□ Change in hair or skin texture □ Rosacea

□ Any other skin or hair problems of concern?_____

_____

HEAD, EYES, EARS, NOSE & THROAT:

□ Dizziness □ Concussions □ Migraines □ Glasses

□ Eye strain □ Eye Pain □ Poor Vision □ Night blindness

□ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing

□ Spots in field of vision □ Nose bleeds □ Grinding teeth

□ Sinus problems □ Recurrent sore throats □ Facial pain

□ Sores on lips or tongue □ Teeth problems □ Jaw clicks

□ Headaches, where and when?_____

_____

Any other head or neck problems? _____

_____

CARDIOVASCULAR:

□ High blood pressure □ Low blood pressure □ Chest pain □ Fainting

□ Irregular heart beat □ Difficulty breathing □ Blood clots □ Phlebitis

□ Cold hands or feet □ Swelling of hands □ Swelling of feet

□ Varicose or spider veins □ Palpitations □ Palpitations at rest

Any other heart or blood vessel problems?_____

RESPIRATORY:

□ Cough □ Coughing blood □ Asthma □ Bronchitis

□ Pneumonia □ Pain w/deep breath □ Chest tightness

□ Difficulty breathing when lying down

□ Phlegm production: nose / throat, what color?_____

GASTROINTESTINAL:

□ Nausea □ Vomiting □ Diarrhea □ Constipation

□ Gas □ Belching □ Black Stools □ Blood in stools

□ Indigestion □ Bad Breath □ Rectal Pain □ Hemorrhoids

□ Bleeding gums □ Ulcer □ Bloating/edema □ Acid reflux/GERD

□ Hernia □ Excessive appetite □ Poor appetite □ IBS/Chrohn's Disease

□ Colitis □ Slow digestion □ Abdominal pain/cramps

□ Loose stools, more than 2 per day

□ Any other problem with Stomach or Intestines?_____

GENITO-URINARY:

□ Frequent Urination □ Blood in urine □ Pain upon urination

□ Urgency to urinate □ Unable to hold urine □ Kidney stones

□ Decrease in flow □ Impotency □ Sores on genitals

Any particular color to your urine?_____

Do you wake up at night to urinate? If yes, how many times a night? _____

Any other problems with your genital or urinary systems?_____

_____

MALE:

□ Genital Itching □ Genital Pain, where & when?_____

□ Erection difficulties

□ Do you practice birth control?_____

FEMALE:

Are you pregnant? □ Yes □ No

Is it possible that you pregnant? □ Yes □ No

Are you in perimenopause? □ Yes □ No

Are you in menopause? □ Yes □ No If yes, since when?_____

Number of pregnancies:_____ Live Births:_____ Miscarriages:_____

Abortions:_____ Premature births:_____

Age at first menses:_____ Time period between menses:_____

Duration of menses:_____ Date of last menses:_____ Last PAP:_____

□ Irregular Periods □ Pain periods □ Clots □ Breast lumps

□ Vaginal sores □ Vaginal Discharge □ Vaginal dryness □ Uterine Fibroids

□ Unusual character of blood (heavy, scanty)_____

□ Endometriosis □ Polycystic Ovarian Disease □ Fibrocystic breast tissue

Do you practice birth control? Yes No If yes, what type?_____How long?_____

MUSCULOSKELETAL:

□ Neck pain □ Rotator Cuff □ Knee pain □ Foot/ankle pain

□ Muscle pain □ Muscle spasm □ Muscle weakness □ Shoulder pain

□ Hip pain □ Sciatica □ Bursitis □ Hand/wrist pain

□ Carpal tunnel □ Sprains/strains □ Tendonitis

□ Back pain: Low_____ Middle_____ Upper_____

□ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PHYCHOLOGICAL:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness

□ Poor memory □ Concussion □ Poor coordination □ Bad temper

□ Anxiety □ Depression □ Easily susceptible to stress

□ Nervousness □ ADD/ADHD □ Manic depression

Have you ever been treated for emotional problems? Yes No

Have you ever considered or attempted suicide? Yes No

Any other neurological or psychological issues?_____

_____

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

_____

_____

_____

_____

_____

_____

_____