

MORGAN HILL ACUPUNCTURE
17705 Hale Avenue #H-5
Morgan Hill, CA 95037

NAME _____
DATE _____
Date of Birth _____

Health History Questionnaire

All information in this questionnaire will be a part of your medical record and is strictly confidential.

Please briefly describe your major complaint:

What are your goals for treatment:

What have you tried to help make this condition better?

Medical History: Please check all that apply

- | | |
|-----------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergies to cosmetics |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis: What kind? |
| <input type="checkbox"/> Cancer: What kind? | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Mitral valve defect/prolapse |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Other | |

Injuries, Surgeries, Major Illnesses

Please provide details & dates of childhood injuries, surgeries or major illness

Adult injuries, surgeries or major illnesses

Please List Any Medications or Supplements You are Currently Taking:

Please write down the typical foods you eat for:

Breakfast

Lunch

Dinner

Snacks

How many per day?

Food Cravings?

Food Intolerances?

How many glasses/cups do you drink each day of the following?

Water _____ Soda _____ Coffee _____ Tea _____ Wine _____ Beer _____

How many servings per day/week do you consume of?

Beef _____ Chicken _____ Fish _____ Dairy (milk, cheese, yogurt) _____ Sugar/sweets _____

Do you perspire during the day? _____ at night? _____

Are you always thirsty? Yes _____ No _____

Do you prefer hot drinks or cold drinks?

PHYSICAL ACTIVITY

What kind of exercise do you engage in?

How often?

How is your general energy level?

DIGESTION: Do you have or have you had?

Belching

Nausea

Vomiting

Ulcers

Indigestion

Heartburn

Hernia

Hemorrhoids

EMOTIONS & SLEEP

Panic attacks

Depression

Anxiety

Nerves

Fear

Poor memory

Difficulty concentrating

Takes anti-depressants What kind?

Takes sleeping pills What kind?

<input type="checkbox"/> Difficulty Falling asleep	<input type="checkbox"/> Restless sleep
<input type="checkbox"/> Disturbed sleep	<input type="checkbox"/> Wakes up at _____ am/pm
URINARY SYSTEM	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Difficult urination
<input type="checkbox"/> Burning/itching	<input type="checkbox"/> Bladder infections
RESPIRATORY/EENT	
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Asthma
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold sores
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Clogged/popping ears	<input type="checkbox"/> Frequent headache
<input type="checkbox"/> Migraines	<input type="checkbox"/> Allergies?
<input type="checkbox"/> Allergic to:	
<input type="checkbox"/> Allergy symptoms:	
CARDIOVASCULAR	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Spider veins	<input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Irregular heart beat	
SKIN & HAIR	
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Dry scalp, dandruff
<input type="checkbox"/> Itching	<input type="checkbox"/> Acne
<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Hives	<input type="checkbox"/> Thinning or loss of hair
WOMEN ONLY - OB/GYN	
<input type="checkbox"/> Are you still menstruating? Yes No	<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Heavy flow	<input type="checkbox"/> Light flow
<input type="checkbox"/> No flow	<input type="checkbox"/> Blood clots in menstrual blood
<input type="checkbox"/> PMS	<input type="checkbox"/> Cramps/painful periods
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Are you trying to get pregnant? Yes No
<input type="checkbox"/> Infertility problems how long?	<input type="checkbox"/> Miscarriage # of times _____
<input type="checkbox"/> How many children to you have?	<input type="checkbox"/> Perimenopause
<input type="checkbox"/> Hotflashes # per day	<input type="checkbox"/> Nightsweats
MEN ONLY	
<input type="checkbox"/> Do you usually get up at night to urinate?	<input type="checkbox"/> Blood in urine?
<input type="checkbox"/> Decreased force of urination	<input type="checkbox"/> Difficulty with ejaculation or erection
<input type="checkbox"/> Testicle pain or swelling	<input type="checkbox"/> Prostate/rectal exam was done in the last year
ANY ADDITIONAL HEALTH CONCERNS:	

