HISTORY QUESTIONNAIRE (2017)

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Date: ____/____/______

Name: Mr./Mrs./Ms.____ Date of Birth: ____/____/____

Address: __________________________ City _______________ State ________ Zip Code ___________

Phone: (C)(______)__________________(W)(______)_________________(Other)___________________

Email address:_______________________________Guardian (if under 18): ________________________

Emergency Contact: Name___________________ Relationship___________Phone#________________

Gender: ☐M ☐F Age: ______Height: ____'____" Weight: ______lbs. Blood Pressure: _____/_____

Occupation: ____________________________ Employer: ____

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Occupation: ____________________________ Spouse's Employer: ________________________

Children (Male/Female, age): _______________, _______________, _______________, _______________

PCP Name: _______________________________ Specialist Name: ________________________________

How did you hear about our office? ____

Do you have a tendency to faint? Yes No
Do you have a pacemaker? Yes No
Do you bleed for a long time? Yes No

Are you HIV positive? Yes No
(Females) Are you pregnant? Yes No
Have you ever had hepatitis? Yes No

II. Patient Medical History

Major Complaint(s), in order of significance to you:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

Additional: ______________________________

How do these conditions impair your daily activities? ____

Hospital Visits/Stays: ____

Medication (name, dosage): ____

Supplements: ____

____

Patient Initial______

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Please indicate if you have (or had) any of the following:			
☐ Diabetes	☐ Allergies	☐ Rheumatic Fever	☐ Vein Condition
☐ Heart Disease	☐ CVA (stroke)	☐ Thyroid Disorder	☐ Tuberculosis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Chicken Pox
☐ High Blood Pressure	☐ Gonorrhea	☐ Bleeding Tendency	☐ Polio
☐ Syphilis	☐ Measles	☐ Nervous Disorder	☐ Migraines
☐ Meningitis	☐ Chlamydia	☐ Mononucleosis	☐ Other Liver Illnesses
☐ Epilepsy	☐ High Fever	☐ Multiple Sclerosis	☐ Other Heart Illnesses
☐ Paralysis	☐ Cancer	☐ Jaundice	☐ Other Kidney Illnesses
☐ Glaucoma	☐ Mumps	☐ Hepatitis	☐ Other Lung Illnesses

SURGERIES?
____
____
____
____

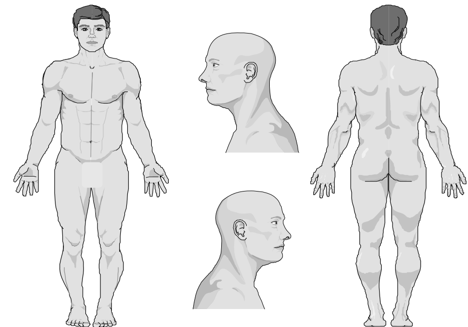
RADIATION/CHEMOTHERAPY?
____
____
____
____

1. Pain:

On the figures below, please mark clearly any areas of pain and indicate any scars.

What makes the pain better?
☐ Soft Preassure
☐ Hard Pressure
☐ Cold
☐ Heat
☐ Exercise
☐ Rest
☐ Other

What makes the pain worse?
☐ Soft Pressure
☐ Hard Pressure
☐ Cold
☐ Heat
☐ Exercise
☐ Other



2. Describe your pain:

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other:________________________

3. Kidney Function: (Overall Temperature)

- ☐ Cold Hands
- ☐ Cold Fingers
- ☐ Cold Toes
- ☐ Cold Feet
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Hot Body Temperature Sensation
- ☐ Cold Body Temperature Sensation
- ☐ Afternoon Flushes
- ☐ Night Sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Do you take water to bed

Patient Initial:________

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

4. Lung, Kidney Function: (Overall Energy)

- [ ] Shortness of Breath
- [ ] Difficulty keeping eyes open (daytime)
- [ ] General Weakness
- [ ] Easily catch colds
- [ ] Low Energy
- [ ] Feel worse after exercise
- [ ] Chronic (daily) fatigue & malaise

5. Heart Function:

- [ ] Anxiety
- [ ] Sores on tip of tongue
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Chest pain traveling to shoulder
- [ ] Frequent dreams
- [ ] Wake unrefreshed
- [ ] Coffee? How much per day?_______

6. Lung Function:

- [ ] Nasal Discharge (color___________)
- [ ] Cough
- [ ] Nose Bleeds
- [ ] Sinus Congestion
- [ ] Dry Mouth
- [ ] Dry Throat
- [ ] Dry Nose
- [ ] Dry Skin
- [ ] Allergies (what?_________________)
- [ ] Alternating Chills/Fever
- [ ] Sneezing
- [ ] Headache (location______________)
- [ ] Overall achy feeling in body
- [ ] Stiff Neck
- [ ] Stiff Shoulders
- [ ] Sore Throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (# per day_______)
- [ ] Sadness

7. Dampness trapped in the Body:

- [ ] Bodily sensation of heaviness
- [ ] Mental fogginess
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea

8. Liver, Spleen, Heart Function:

- [ ] Dizziness
- [ ] See floating black spots

9. Liver Function (eyes):

- [ ] Itchy
- [ ] Bloodshot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry Vision
- [ ] Decreased Night Vision

10. Spleen Function:

- [ ] Low Appetite
- [ ] Abrupt Weight Gain
- [ ] Abrupt Weight Loss
- [ ] Abdominal Bloating
- [ ] Abdominal Gas
- [ ] Gurgling noise in Stomach
- [ ] Fatigue after eating
- [ ] Prolapsed Organs? Which?_________
- [ ] Bruise easily?
- [ ] Over-Thinking
- [ ] Worry

11. Spleen, Stomach, Small/Large Intestine Function :

- [ ] Loose Stools
- [ ] Constipated
- [ ] Incomplete Stools
- [ ] Diarrhea
- [ ] Blood in Stools
- [ ] Mucous in Stools
- [ ] Undigested food in the Stools

12. Stomach Function:

- [ ] Burning sensation after eating
- [ ] Large appetite
- [ ] Bad Breath
- [ ] Canker Sores (mouth)
- [ ] Bleeding, swollen or painful gums
- [ ] Heartburn
- [ ] Acid Regurgitation
- [ ] Ulcer (diagnosed?)
- [ ] Belching
- [ ] Hiccups
- [ ] Stomach Pain
- [ ] Vomiting

Patient Initial:________

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

- [ ] Snoring

13. Liver, Gall Bladder Function:

- [ ] Alternating Diarrhea & Constipation
- [ ] Chest Pain
- [ ] Tight sensation in the Chest
- [ ] Bitter taste in the mouth
- [ ] Anger easily
- [ ] Depression
- [ ] Frustration
- [ ] Irritability
- [ ] Skin Rashes
- [ ] Headache at the top of the Head
- [ ] Tingling Sensation
- [ ] Numbness
- [ ] Muscle twitching
- [ ] Muscle Spasms
- [ ] Seizures
- [ ] Convulsions
- [ ] Lump in the throat
- [ ] Neck Tension
- [ ] Shoulder Tension
- [ ] How much Alcohol / day?__________
- [ ] High-pitched Ringing in Ears
- [ ] Gallstones (history or current)
- [ ] Unable to adapt to Stress

14. Kidney, Urinary Bladder Function:

- [ ] Frequent cavities, teeth problems
- [ ] Easily broken bones
- [ ] Weak knees
- [ ] Cold sensation in the knees
- [ ] Low Back Pain
- [ ] Memory problems
- [ ] Excessive hair loss
- [ ] Low-pitched ringing in the ears
- [ ] Kidney Stones
- [ ] Bladder Infections
- [ ] Lack of bladder control
- [ ] Wake during the night 2 (or more) times to urinate?
- [ ] Fear
- [ ] Easily startled

15. Urination (Bladder Function):

Color (please check):

- [ ] Pale____; Dk Yellow____; Clear____
- [ ] Reddish
- [ ] Cloudy
- [ ] Scanty
- [ ] Profuse
- [ ] Strong Oder
- [ ] Burning
- [ ] Painful
- [ ] Discharge
- [ ] Difficult
- [ ] Urgent
- [ ] Frequent

16. Libido:

- [ ] Normal
- [ ] High
- [ ] Low

Men Only:

- [ ] Swollen testes
- [ ] Testicular pain
- [ ] Impotence
- [ ] Premature ejaculation
- [ ] Feeling of coldness or numbnesss in external genitalia
- [ ] Other?

Women Only (PMS conditions)

- [ ] Nausea
- [ ] Vomiting
- [ ] Food cravings
- [ ] Water retention
- [ ] Breast swelling
- [ ] Breast tenderness
- [ ] Headaches
- [ ] Migraines
- [ ] Dull pain (where?__________)
- [ ] Sharp pain (where?___________)
- [ ] Depression
- [ ] Irritability
- [ ] Anxiety
- [ ] Other (explain_____________)

Patient Initial:________

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

WOMEN ONLY		
☐ Yes ☐ No	Do you have a regular menstrual cycle?	_______ Age of first menstruation
☐ Yes ☐ No	Are you pregnant?	_______ Average number of days in flow
☐ Yes ☐ No	Do you have bleeding beetween periods?	_______ Average number of days in entire cycle
☐ Yes ☐ No	Do you have a vaginal discharge?	_______ Number of children
	Color?	_______ Number of pregnancies
	☐ Clear ☐ White ☐ Yellow	_______ Age of menopause (if applicable)
	Odor?	
	☐ No ☐ Strong ☐ Fishy	

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): normal, pale, bright red, brown rust, dark purple, other							
Amount of flow (choose one): normal, heavy, light							
Pain/Cramps (choose one): dull, sharp, other							
Vomiting (check if yes):							
Nausea (check if yes):							

Patient Initial:________