NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Lee Acupuncture, Inc.
425 Old Newport Blvd Suite E Newport Beach, CA 92663

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 your diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Date: ____/____/____

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

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____

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 (Name & age): _____, _____, _____, _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Primary Doctor's Name: _____ Specialist's Name: _____

How did you hear about our office? _____

Do you have a tendency to faint?	☐ Yes	☐ No	Are you HIV positive?	☐ Yes	☐ No
Do you have a pacemaker?	☐ Yes	☐ No	Have you ever had Hepatitis?	☐ Yes	☐ No
Do you have a nickel allergy?	☐ Yes	☐ No	(Female) Are you pregnant?	☐ Yes	☐ No

II. Patient Medical History

Major Complaint(s), in order of significance to you:	Start Date (mm/yy)	Level of discomfort (1-10) *Least----------Worst*
1. _____	____/____	1 2 3 4 5 6 7 8 9 10
2. _____	____/____	1 2 3 4 5 6 7 8 9 10
3. _____	____/____	1 2 3 4 5 6 7 8 9 10
4. _____	____/____	1 2 3 4 5 6 7 8 9 10

How do these conditions impair your daily activities? _____

Hospital Visits/Stays: _____

Medication (name, dosage): _____

Supplements: _____

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Please indicate if you have (or had) any of the following:

☐ Diabetes	☐ Eczema	☐ Bleeding Tendency	☐ Other Liver Illnesses
☐ Heart Disease	☐ Glaucoma	☐ Mononucleosis	☐ Other Kidney Illnesses
☐ High Blood Pressure	☐ Epilepsy	☐ Anemia	☐ Other Lung Illnesses
☐ High Cholesterol	☐ CVA (stroke)	☐ Addictions _____	
☐ Asthma	☐ Migraines	☐ Auto Immune _____	
☐ Allergies	☐ Thyroid Disorder	☐ Cancer _____	

SURGERIES? (Date of procedure, Description)

_____
_____
_____
_____
_____

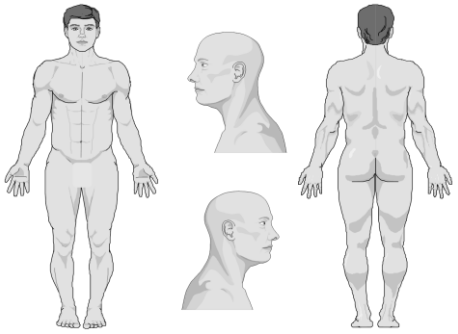
RADIATION/CHEMOTHERAPY?

_____
_____
_____
_____
_____

1. Pain:

How Did you get injured? _____
_____

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



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

2. Describe your pain:

☐ Sharp
☐ Fixed
☐ Burning
☐ Moving
☐ Cramping
☐ Aching
☐ Dull
☐ Other: _____

3. Kidney Function: (Overall Temperature)

☐ Cold Hands
☐ Cold Feet
☐ Sweaty Hands
☐ Sweaty Feet
☐ Prefer cold drinks
☐ Prefer hot drinks
☐ Prefer room temperature drinks
☐ Night Sweats
☐ Heat in the hands, feet & chest
☐ Hot flashes any time of the day
☐ Thirsty

4. Lung, Kidney Function: (Overall Energy)

☐ Shortness of breath
☐ Low Energy
☐ Feel worse after exercise
☐ Chronic (daily) fatigue & malaise

5. Heart Function:

☐ Anxiety
☐ Sores on tip of tongue
☐ Mental confusion
☐ Chest pain traveling to shoulder
☐ Frequent dreams
☐ Wake up unrefreshed
☐ Coffee? How much per day? _____
☐ Sleeping problem? _____

Patient's Initials:_____

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6. Lung Function:

- ☐ Cough
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Skin
- ☐ Allergies (what?_____)
- ☐ Sneezing
- ☐ Headache (Location: front, back, side or top)
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# per day_____)

7. Dampness trapped in the Body:

- ☐ Bodily sensation of heaviness
- ☐ Mental fogginess
- ☐ Swollen hands, feet, joints
- ☐ Nausea
- ☐ Dizziness

8. Spleen Function:

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling noise in Stomach
- ☐ Fatigue after eating
- ☐ Bruise easily

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

- ☐ Loose Stools
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Mucous in Stools

10. Stomach Function:

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Snoring

11. Liver, Gall Bladder Function:

- ☐ Alternating Diarrhea & Constipation
- ☐ Constipation
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily
- ☐ Depression
- ☐ Frustration
- ☐ Irritability
- ☐ Skin Rashes
- ☐ Headache at the top of the head
- ☐ Numbness, tingling sensation
- ☐ Muscle twitching
- ☐ Muscle Spasms
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Shoulder Tension
- ☐ How much Alcohol per day?_____
- ☐ High-pitched ringing in Ears

12. Kidney, Urinary Bladder Function:

- ☐ Frequent cavities, teeth problems
- ☐ 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 up during the night 2 (or more) times to urinate
- ☐ General/unspecified fear

13. Urination (Bladder Function):

- ☐ Color? (Dark, Yellow or Clear)
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning sensation
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

14. Libido:

- ☐ Normal
- ☐ High
- ☐ Low

Patient's Initials:_____

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Men Only:

- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Feeling of coldness or numbness in external genitalia
- ☐ Other?

Cycling 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:_____)

CYCLING WOMEN ONLY

Do you have a regular menstrual cycle? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐
Do you have bleeding between periods? Yes ☐ No ☐
Do you have a vaginal discharge? Yes ☐ No ☐
If yes, Color?
☐ Clear ☐ White ☐ Yellow
Odor?
☐ No ☐ Strong ☐ Fishy

Age of first menstruation _____
Average number of days in flow _____
Average number of days in entire cycle _____
Number of children _____
Number of pregnancies _____
Age of menopause (if applicable) _____

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's Initials:_____