Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask.

Thank You

Name: Sam Rothstein		Phone: Home:( )		Work: ( )
Street:		Age:	Height:	Weight:
City		Occupation:		Gender (M/F):
State:	Zip:	Date of Birth:		
Place of Birth:		Marital Status:		
Family Physician:		Social Security No:		
In Emergency Notify:		Tel. No.: ( )		
Referred By:				
Have you been treated by acupuncture before?:				
Main problem(s) with which you would like help				
Problem or Disease:				
How long ago did this problem begin?:				
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?				
How long ago did this problem begin (be specific):				
Have you been given a diagnosis for this problem?:				
What kind of treatment have you tried?:				
Past Medical History (please include dates)				
Significant Illnesses: Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease				
Surgeries:				
Significant Trauma (auto accidents, falls, etc.)				
Birth History (prolonged labor, forceps delivery, etc.):				
Allergies (drugs, chemicals, foods):				

Family Medical History

☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Seizures ☐ Asthma
☐ Allergies ☐ Stroke ☐ Heart Disease

Occupation

Occupational Stress (chemical, physical, physiological. Etc.)
Do you have a regular exercise program? Please describe.

Medicines taken within the last two months (Include vitamins, over-the-counter drugs, herbs, etc)

Are you now or have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:
Morning: Afternoon: Evening:

How many packs of cigarettes a day do you smoke? _____

How much coffee, tea or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes:

General

- ☐ Poor Appetite
- ☐ Poor Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Tremors
- ☐ Cravings
- ☐ Localized Weakness
- ☐ Poor Balance
- ☐ Change in appetite
- ☐ Bleed or Bruise Easily
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Peculiar Tastes or Smells
- ☐ Strong Thirst (cold or hot drinks)
- ☐ Sudden Energy Drop (What time of day?) _____

Skin and Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent Moles
- ☐ Change in Hair or Skin Texture

Any Other hair or skin problems? _____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Cataracts
- ☐ Blurry Vision
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Spots in Front of Eyes
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throats
- ☐ Grinding Teeth
- ☐ Facial Pain
- ☐ Sores
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Headaches (Where and When?) _____

Any other head or neck problems? _____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Swelling of the Hands
- ☐ Swelling of the Feet
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Difficulty in Breathing

Any other heart or blood vessel problems? _____

Respiratory

- ☐ Cough
- ☐ Coughing Blood
- ☐ Chest Pain
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a Deep Breath
- ☐ Difficulty in Breathing when Lying Down
- ☐ Production of Phlegm (What color?)

Any other lung problems? _____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Gas ☐ Belching
☐ Black Stools ☐ Blood in Stools ☐ Indigestion
☐ Bad Breath ☐ Rectal Pain ☐ Hemorrhoids
☐ Abdominal Pain or Cramps
☐ Chronic Laxative Use
Any other problems with your stomach or intestines? _____

Genito-Urinary

☐ Pain on Urination ☐ Frequent Urination ☐ Blood in Urine
☐ Urgency to Urinate ☐ Unable to Hold Urine ☐ Kidney Stones
☐ Decrease in Flow ☐ Impotence ☐ Sores on Genitals
Do you wake up to urinate? _____ How often? _____
Any particular color to your urine? _____
Any other problems with your genital or urinary system? _____

Pregnancy and Gynecology

____ Number of pregnancies ____ Number of Births ____ Premature Births
____ Miscarriages ____ Abortions ____ Age at first Menses
____ Period between menses ____ Duration First date of last menses _____
☐ Unusual Character (Heavy or Light)
☐ Painful Periods ☐ Clots ☐ Last PAP
☐ Vaginal Discharge ☐ Vaginal Sores ☐ Breast Lumps
☐ Changes in body / psyche prior to menstruation
Do you practice birth control? _____ What type and for how long? _____

Musculoskeletal

☐ Neck Pain ☐ Muscle Pains ☐ Knee Pain
☐ Back Pain ☐ Muscle Weakness ☐ Foot / Ankle Pains
☐ Hand / Wrist Pains ☐ Shoulder Pain ☐ Hip Pain
Any other joint or bone problems? _____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance
☐ Areas of Numbness ☐ Lack of Coordination ☐ Poor Memory
☐ Concussion ☐ Depression ☐ Anxiety
☐ Bad Temper ☐ Easily Susceptible to Stress
Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____

Comments (please tell us of any other problems that you would like to discuss)