Health History Questionnaire

Date _____/_____/_____ Acunow LLC, 2800 W Parker Rd #101, Plano, TX 75075

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 any questions, please ask. If there is anything additional you wish to bring to the attention of the physician, please note it in the ***Comments Section*** *on Page 3. Thank you.*

Name:			Email:	
Address:	City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:	
Date of Birth: / /	Age:	City of Birth:	State of Birth:	Sex: _ Male _ Female
Height: ` "	Weight:	Ethnic Background (check one): __ Caucasian __ African American __ Asian/Pacific Islander __ Native American __ Hispanic (any race) __ Other, please specify _____	Marital Status (check one): __ Never Married __ Separated __ Married __ Divorced __ Widowed __ Living with Partner, Unmarried	
Employer Name:				
Occupation:		Education (highest level achieved): __ Grade School __ Some High School __ High School Graduate __ Some College __ College Graduate __ Graduate or Professional School __ Vocational or Technical School		
Family Physician:				
Referred By:				
Emergency Contact:	Emergency Contact Phone:		Have you been treated with Oriental medicine before? __ Yes __ No	

List the main problem(s) you would like us to help you with: _____
_____

How long ago did this problem begin (be specific)?: _____
_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?: _____
_____

Have you been given a diagnosis for this problem? If so, what?: _____
_____

List the kinds of treatment you have tried: _____
_____

PAST MEDICAL HISTORY

(If applicable, please include date)

____Cancer ____High Blood Pressure ____Thyroid Disease ____Diabetes ____Heart Disease
____Seizures ____Hepatitis ____Rheumatic Fever ____Venereal Disease ____Other

Surgeries (type of and date):_____

_____

Significant Trauma (auto accidents, falls, etc.): _____

_____

Significant Dental Work (type of and date): _____

_____

Allergies (drugs, chemicals, foods, etc. and result): _____

_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Occupational Stress (chemical, physical, psychological, etc.): _____

_____

FAMILY MEDICAL HISTORY

____Cancer ____High Blood Pressure ____Thyroid Disease ____Diabetes ____Heart Disease
____Seizures ____Hepatitis ____Rheumatic Fever ____Venereal Disease ____Other

AVERAGE DAILY ROUTINE

Do you have a regular exercise program? __ Yes __ No Please describe: _____

_____

Have you ever been on a restricted diet? __ Yes __ No Please describe: _____

_____

DAILY DIET

Morning _____
Afternoon _____
Evening _____
How many packs of cigarettes do you smoke per day? ____ How much coffee, tea, or cola do you drink per week? ____
How much alcohol do you drink per week? ____ Describe any use of drugs for non-medical purposes: _____

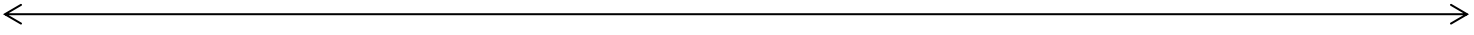
HEALTH INDICATORS

GENERAL	SKIN & HAIR			RESPIRATORY
__ Chills __ Fever __ Sweat easily __ Night sweats __ Localized weakness __ Bleed or bruise easily __ Peculiar tastes or smells __ Strong thirst __ Thirst, no desire to drink __ Fatigue __ Energy drop *Time of day?*_____ __ Edema *Where?*_____ __ Tremors __ Poor balance __ Cravings __ Change in appetite __ Weight loss __ Weight gain	__ Rashes __ Itching __ Cravings __ Change in hair or skin __ Ulcerations __ Eczema __ Oozing on skin lesion __ Hives __ Pimples __ Recent moles __ Loss of hair __ Dandruff *Other hair or skin problems:* _____ HEAD, EYES, EARS, & THROAT __ Dizziness __ Migraines __ Headaches *When?* _____ *Where?* _____	__ Facial pain __ Glasses __ Poor vision __ Night blindness __ Blurry vision __ Color blindness __ Blind field __ Spots in front of eyes __ Eye pain __ Eye strain __ Cataracts __ Eye dryness __ Excessive tearing __ Discharge from eyes __ Poor hearing __ Ringing in ears __ Earaches __ Discharge from ear __ Nose bleeds __ Sinus congestion __ Nasal drainage __ Grinding teeth __ Concussion __ Recent sore throats	__ Hoarseness __ Dry throat __ Dry mouth __ Copious saliva __ Gum problems __ Sores on lips or tongue *Other head or neck problems:* _____ CARDIOVASCULAR __ High blood pressure __ Low blood pressure __ Chest discomfort/pain __ Heart palpitations __ Cold hands or feet __ Swelling of feet __ Blood clots __ Fainting __ Difficulty breathing *Other heart or blood vessel problems:* _____	__ Cough __ Asthma/wheezing __ Pain with a deep breath __ Difficulty breath when lying down __ Coughing blood __ Pneumonia __ Bronchitis *Other lung problems:* _____ GASTROINTESTINAL __ Bad breath __ Nausea __ Vomiting __ Heartburn __ Belching __ Indigestion __ Diarrhea __ Constipation __ Chronic laxative use __ Blood in stools __ Abdominal pain or cramps

__ Gas __ Rectal pain __ Hemorrhoids *Other stomach or intestinal problems:* _____ GENITO-URINARY __ Pain when urinating __ Urgency to urinate __ Frequent urination __ Blood in urine __ Decrease in flow __ Unable to hold urine __ Dribbling __ Kidney stones __ Impotency __ Change in sexual drive __ Sores on genitals	__ Wake up to urinate? *How often?* _____ *Color of urine:* _____ *Other genital or urinary system problems:* _____ PREGNANCY & GYNECOLOGY # of pregnancies:__ # of births: __ # of premature babies:__ # of miscarriages: __ # of abortions:__ Age at first menses: __ Period between menses (days): __	Duration of menses (days): __ *First day of last menses:* __/__/____ __ Heavy periods __ Light periods __ Painful periods __ Irregular periods __ Changes in body/psyche prior to menstruation __ Clots Menopause: *Age* _____ *Year* _____ __ Vaginal discharge __ Postcoital bleeding __ Vaginal sores *Date of last pap:* __/__/__	__ Breast lumps __ Nipple discharge *Do you practice birth control?* _____ *What type? For how long?* _____ MUSCULOSKELETAL __ Neck pain __ Shoulder pain __ Back pain __ Elbow pain __ Hand/wrist pain __ Hip pain __ Knee pain __ Foot/ankle pain __ Muscle pain __ Muscle weakness *Other muscular problems:* _____	NEUROPSYCHOLOGICAL __ Seizures __ Areas of numbness __ Weakness __ Sleep disorder __ Concussion __ Bad temper __ Loss of control __ Vertigo __ Lack of coordination __ Depression __ Easily susceptible to stress __ Poor memory __ Anxiety __ Substance abuse *Have you ever been treated for emotional problems?* __ *Have you ever considered or attempted suicide?* __

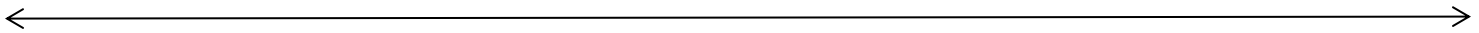
SEVERITY

Please note the degree of severity of your problem now:



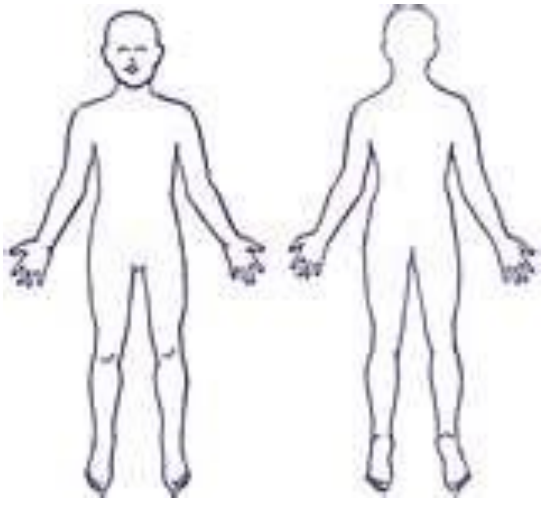
No Problem — Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:



No Problem — Worst Imaginable

Indicate painful or distressed areas:



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

_____

_____

_____

_____

_____

_____

_____