**Health History Questionnaire**

**Boston Chinese Acupuncture Clinic**

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In order for us to better service you please fill out this questionnaire carefully. All of your answers will be held absolutely confidential. It there is anything you want to bring to our attention, which is not asked on this form, please note in the "comments" section. Thank you.

Name: Sex: Male Female

Date of birth: Referred by: Occupation:

Address:

Street

Apt.

City

State

Zip

Cell phone: **email:**

Marital status Emergency contact

Have you been treated with acupuncture or oriental medicine before? Yes No

Main concern(s) you would like for us to help you with

When did this problem begin? Please be specific

To what extent does this problem interfere with your daily activities?

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

What kind of treatment have you tried?

**Medical History (please specify all that apply)**

Cancer Diabetes Hepatitis A B C High blood pressure

Heart disease Rheumatic fever Seizures Stroke

Thyroid disease Venereal Disease Other

Surgeries

Significant trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods)

Medications taken in the past two months (vitamins, drugs, herbs, etc.)

Have you ever been on a restricted diet? If yes, what kind?

Do you smoke? If yes, how much?

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

Indicate any painful or distressed areas:

**Please specify if you have had (in the past three months):**

**General**

Poor sleeping Night sweats Fevers Chills

Cravings Sweat easily Weight loss Change in appetite

Bleed or bruise easily Strong thirst (hot or cold drinks) Weight gain

Peculiar tastes or smells Fatigue

Sudden energy drop (what time of a day?)

**Skin & Hair**

Rashes Ulceration Hives Fevers

Itching Eczema Pimples Dandruff

Loss of hair Recent moles Changes 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 on lips or tongue

Teeth problems Jaw clicks Headaches (where, when?)

**Cardiovascular:**

High blood pressure Low blood pressure Chest pain

Irregular heartbeat Swelling of hands Fainting

Cold hands and feet Phlebitis Swelling of feet

Blood clots Difficulty in breathing

Any other heart and blood vessel problems

**Respiratory:**

Cough Coughing blood Asthma

Bronchitis Pneumonia Pain with a deep breath

Difficulty in breathing when take deep breath Production of phlegm; what color

Broncheectosis Loss of sense of smell and taste Sneezing and sinisitis

**Gastrointestine**

Nausea Vomiting Diarrhea

Constipation Gas Belching

Black stool Blood in stools Indigestion

Bad breath Rectal pain Hemorrhoids

Abdominal pain or cramps Chronic laxative use Poor appetites

Any other problems with your stomach or intestines

**Genito-Urinary**

Pain upon urination How many times per day do you urinate:

Blood in urine Urgency to urinate Unable to hold urine

Kidney stones Decrease in urine flow Impotence Impotence

Sores on genitals Do you wake up to urinate? How often

Any particular color of your urine

Any other problems with your genital or urinary system

**Musculoskeletal**

Neck pain Muscle pain: Knee pain Back pain

Muscle weakness Foot/ankle pains Hand/wrist pains Shoulder pain

Hip pain Any other joint or bone problems

**Neuropsychological**

Seizure Lack of coordination Loss of balance

Areas of numbness Depression Poor memory

Concussion Easily susceptible to stress Anxiety

Bad temper Tremors

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

# Men only

Genital pain Impotence Genital sores Lump in testicles

Penis discharge Nocturnal emission Low sexual energy

**Women Only**

**Reproductive and gynecologic issues**

#of pregnancies\_\_\_ # of live births\_\_\_ # of premature births\_\_\_

# of miscarriages\_\_\_ # of abortions\_\_\_

Vaginal discharge Menstral clots Unusual periods (heavy, light, etc)

Irregular periods Menstral pain Spotting or pain between periods

Date of last pap\_\_\_\_ Results:\_\_\_\_\_

Age of 1st menses\_\_\_ Menopause age\_\_\_

Date of last period\_\_\_\_\_ How many days period lasts\_\_\_\_

Number of days between periods\_\_\_

Changes in body/psyche prior to period

Do you practice birth control? Yes No What type and for how long?

Is there any chance that you are pregnant now? Yes No

**Comments:**

Please tell us any other problems you would like to let us know