Elizabeth M. Fay, Lic. Ac.
ACUPUNCTURE and CHINESE HERBAL MEDICINE IN NEWTON and CAMBRIDGE, MA

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. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the "comments" section. Thank you.

basic information

First name | Last name | Date

Address | City

State | Zip | Date of birth

Primary phone | Secondary phone

E-mail | Occupation

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced or separated

Primary care physician | Phone number

Emergency contact | Phone number

How did you find us? | Referred by

Have you ever been treated by acupuncture or oriental medicine before? ☐ Yes ☐ No

reason for visit

What is the main problem you would like us to treat?

How long have you been experiencing this problem? Please be specific.

What other kinds of treatment have you tried?

Are there any secondary problems you would like us to treat?

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health history questionnaire

medical history

Personal medical history

☐ Asthma ☐ Cancer ☐ Allergies ☐ Heart disease ☐ Rheumatic fever
☐ Stroke ☐ Seizures ☐ Diabetes ☐ Thyroid disease ☐ Venereal disease
☐ High blood pressure Other

Allergies (e.g. drugs, chemicals, foods)

Hospitalizations and surgeries (include dates)

Significant trauma (e.g. car accidents, falls)

Medicines taken within the last 2 months (e.g. drugs, vitamins, herbs)

Family medical history

☐ Asthma ☐ Cancer ☐ Allergies ☐ Heart disease ☐ Rheumatic fever
☐ Stroke ☐ Seizures ☐ Diabetes ☐ Thyroid disease ☐ Venereal disease
☐ High blood pressure Other

lifestyle

Do you follow any special diet (e.g. vegetarian, vegan, medical related)? ☐ Yes ☐ No

If yes, plese describe

Describe your average daily diet

Morning

Afternoon

Evening

How many cups of caffeinated coffee, tea, or cola do you drink per week?

How many 8oz glasses of water do you drink per day?

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health history questionnaire

lifestyle (continued)

How many alcoholic beverages do you drink per week?

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day?

Describe any drug use for non-medical purposes

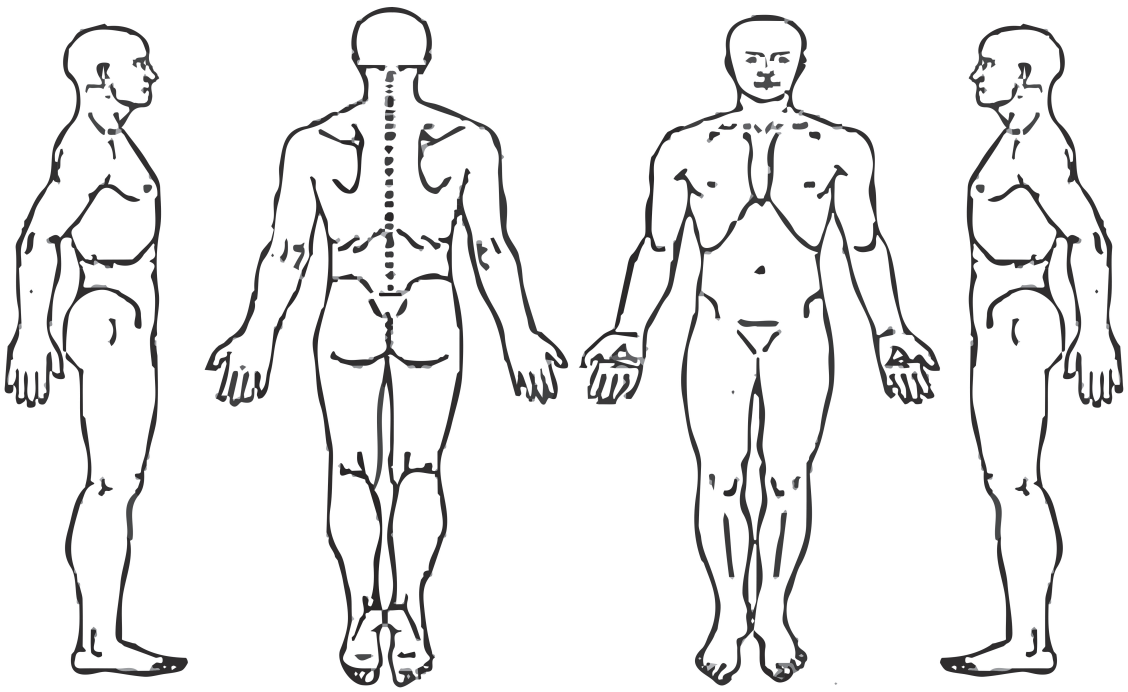
Are there areas of your life you find stressful? Please describe.

Do you follow a regular exercise program? ☐ Yes ☐ No

If yes, please describe

symptoms

Please indicate any painful or distressed areas of your body by circling on the diagram



health history questionnaire

symptoms (continued)

Please check off all symptoms you have experienced, particularly in the last three months

General

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Sweat easily
- ☐ Poor sleeping
- ☐ Night sweats
- ☐ Weight loss
- ☐ Cravings
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop — If so, what time of day? _____
- ☐ Bleed or bruise easily
- ☐ Strong thirst for ☐ hot drinks ☐ cold drinks

Skin and hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Acne
- ☐ Change in hair or skin texture
- ☐ Other skin or hair problems _____

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Wear glasses
- ☐ Color blindness
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Night blindness
- ☐ Seeing spots
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Facial pain
- ☐ Nose bleeds
- ☐ Recurring sore throat
- ☐ Lip or tongue sores
- ☐ Clenching jaw
- ☐ Jaw clicking
- ☐ Tooth grinding
- ☐ Tooth problems
- ☐ Sinus problems
- ☐ Headaches — If so, where and when? _____
- ☐ Other head or neck problems _____

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Chest tightness
- ☐ Pain with deep breaths
- ☐ Difficulty breathing when lying down
- ☐ Phlegm production — If so, what color? _____

health history questionnaire

symptoms (continued)

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Cold hands or feet
- ☐ Fainting
- ☐ Phlebitis
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Varicose or spider veins
- ☐ Palpitations
- ☐ Palpitations at rest
- ☐ Other heart or blood vessel problems

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stool
- ☐ Blood in stool
- ☐ Acid reflux/GERD
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Slow digestion
- ☐ Food stagnation
- ☐ Hernia
- ☐ Bloating/edema
- ☐ Bleeding gums
- ☐ Low appetite
- ☐ Excessive appetite
- ☐ Indigestion
- ☐ Abdominal pain/cramps
- ☐ Chronic laxative use
- ☐ Loose stools, more than 2 per day
- ☐ Other stomach or intestinal problems

Genito-urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals
- Urine color
- ☐ Wake up at night to urinate
- If yes, how many times per night?
- ☐ Other genital or urinary problems

Musculoskeletal

- ☐ Neck pain
- ☐ Rotator cuff
- ☐ Knee pain
- ☐ Muscle pain
- ☐ Muscle spasm
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Sciatica
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Carpal tunnel
- ☐ Sprains/strains
- ☐ Back pain ☐ low ☐ middle ☐ upper
- ☐ Lower body soreness/weakness (back, hip, knee, ankle, foot)
- ☐ Muscle weakness
- ☐ Other musculoskeletal problems

health history questionnaire

symptoms (continued)

Reproductive and gynecological health

Are you pregnant? ☐ Yes ☐ No Is it possible you are pregnant? ☐ Yes ☐ No

Number of pregnacies ____ Live births ____ Age at first menses ____

Premature births ____ Abortions ____ Duration of menses ____

Miscarriages ____ Last PAP ____ Time between menses ____

☐ Uterine fibroids ☐ Breast lumps ☐ Clots ☐ Painful periods ☐ Irregular periods

☐ Vaginal sores ☐ Vaginal dryness ☐ Endometriosis ☐ Vaginal discharge

☐ Polycystic ovarian disease ☐ Fibrocystic breast tissue

☐ Unusual menses (e.g. heavy, scanty) ____

Do you use birth control? ☐ Yes ☐ No

If yes, what type? ____ How long? ____

Neurological and psychological

☐ Seizures ☐ Dizziness ☐ Concussion ☐ Loss of balance ☐ Numbness

☐ Poor memory ☐ Bad temper ☐ Nervousness ☐ Poor coordination ☐ ADD/ADHD

☐ Anxiety ☐ Depression ☐ Manic depression ☐ Easily susceptible to stress

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

☐ Other neurological or psychological probems ____

comments

Please tell us briefly about any other problems you would like to discuss.