

Boulder Community Acupuncture HEALTH HISTORY QUESTIONNAIRE

All Medical History information is confidential.

Referred by: _____

Name _____ Today's Date: _____
 Phone number: _____ Date of Birth: _____
 Mailing address: _____
 Email address: _____

Major Complaint: What is your primary reason for this visit?

- 1)
- 2)
- 3)

What initiates your symptoms? _____

What makes them better? _____ What makes them worse? _____

Your medical doctor's name and phone number _____

Contact name and phone number in case of emergency _____

PERSONAL HISTORY

Check any illnesses or conditions you have or have had in the past:

- | | | | | |
|---|---------------------------------------|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pertussis/Whooping Cough | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Antibiotic Use | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Other: _____ | | | | |

Do you have a PACEMAKER? Yes No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: _____

◆ List the Date and Results of last medical test:

Date	Test	Result	Date	Test	Result
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV test			PSA (prostate)	

Emotions: History of: Mood swings _____ Anxiety _____ Depression _____
 Irritability _____ Abuse _____ Attempted suicide _____

Current Stress Level : mild moderate high extreme

Current Medications (list all you are taking):

Supplements (list all you are taking):

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Treats: _____

How much: Caffeine: _____ Tobacco: _____ Alcohol: _____

After eating do you have: Fatigue Bloating Gas Burping Pain Other: _____

Allergies: List any drugs, foods, or other substance you are allergic/hypersensitive to:

Stools: Constipation: _____ Diarrhea: _____ Alternating: _____

Sleep: Hours/night: _____ Time to bed: _____ Time to wake: _____ Rested in a.m.: _____

Trouble falling asleep _____ Palpitations: _____

Exercise: Type: _____ How often: _____ Energy Level: _____

Energy best at what time of day _____

Women

DLMP: _____ Pregnant? Y N Length of Cycle: _____ #Days Bleeding: _____

Pain: _____ Clots: _____ Flow: _____

Color: _____ PMS: _____ Irritable: _____ Mood Swings: _____

Breasts Tender: _____ Cravings: _____ Fatigue: _____

Birth Control: _____ Pregnancies: _____ Births: _____ Miscarriages: _____

Menarche Age: _____ Vaginal Discharge: _____ Hx Yeast Infxn's: _____

Menopause: Age at Onset: _____ Hot Flashes: _____ Night Sweats: _____

Body System Review

Headache: Location: _____ How often: _____ Type of Pain: _____

Dizziness: _____ Numbness/Tingling: _____ Eyes: Red: _____ Itchy: _____ Watery: _____

Blurry: _____ Floaters: _____ ↓Night Vision: _____ Glasses: _____

Ears: Ringing: _____ Pitch: _____ Other: _____

Throat: Swollen glands/Sore throat: _____

Neck/Shoulder Tension: _____ Joint Pain: Knees: _____ other: _____

Low Back Pain: _____ Shortness of Breath: _____

Comments (anything else you would like to tell us):

Patient Signature: _____ **Date:** _____