

AcuStPete

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HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

Address: _____

Email: _____ Phone #'s _____

Chief Concern _____

Other Concerns _____

When did these problems begin? (Be Specific) _____

How do these complaints affect your daily activities? (work, sleep, relationships) _____

Have you been diagnosed? If so, what is the diagnosis? _____

What kinds of treatments have you tried? _____

Are you Pregnant? _____ Do you have a pacemaker? _____

Medical History for the past six (6) months (include dates) _____

Family Medical History & significant illness (please circle) Cancer Diabetes Hepatitis

Heart Disease High Blood Pressure Stroke Rheumatic Fever Seizures Thyroid Disease

Venereal Disease Allergies Asthma Other _____

Surgeries _____

Significant Trauma (auto accidents, injuries, etc.) _____

Your Birth History (prolonged labor, forceps delivery, etc.) _____

Allergies (drugs, chemicals, foods) _____

Medications taken in the last two (2) months (include vitamins, drugs, herbs, birth control and over the counter) _____

Lifestyle / Occupational Stress (chemical, physical etc.) _____

Do you exercise? _____ **How Regularly?** _____ **Describe** _____

Have you ever been on a restricted diet? _____ **What Kind?** _____

Please describe your average daily diet including meals and snacks:

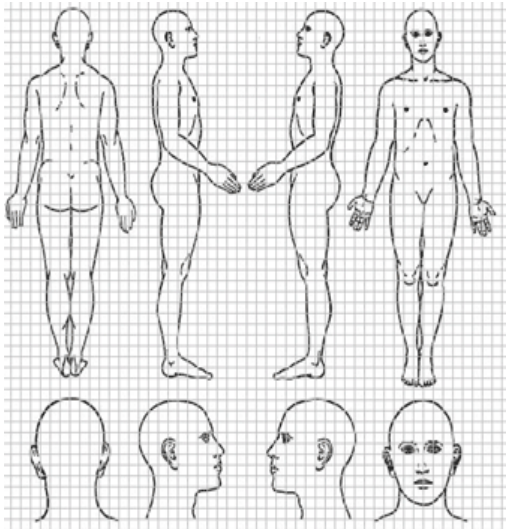
Morning: _____

Afternoon: _____

Evening: _____

Is there anything else you would like us to know about you? _____

Indicate any painful or distressed areas



Please check if you have had within the last three (3) months:

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweats easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Sudden thirst (cold or hot drinks) | | |
- Sudden energy drop (what time of day?) _____

SKIN and HAIR

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | | |
- Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE and THROAT

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strains | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | |

HEADACHES? Where and when? _____

Any other head and / or neck problems? _____

CARDIOVASCULAR

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing |

ANY OTHER HEART OR BLOOD VESSEL PROBLEMS? _____

RESPIRATORY

- Cough
- Coughing blood
- Asthma
- Bronchitis
- Pneumonia
- Pain with deep breath
- Difficulty breathing when lying down
- Production of Phlegm What color? _____
- Any other lung problem? _____

GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas
- Belching
- Black stools
- Blood in stools
- Indigestion
- bad breath
- Rectal pain
- Hemorrhoids
- 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
- impotency
- Sores on genitals
- Do you wake up to urinate? How often? _____
- Any particular color to your urine? _____
- Any other problems with your genitals or urinary system? _____

PREGNANCY & GYNOCLOGY

- Number of pregnancies
- Number of births
- Premature birth
- Miscarriages
- Abortions
- Age @ first menses
- Period between menses
- Duration
- first day of last menses
- Unusual character (heavy or light)
- Irregular periods
- Painful periods
- Clots
- Last PAP
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Changes to body / psyche prior to discharge
- Do you practice birth control? _____ What type and for how long? _____

MUSCULOSKELATAL

- Neck pain
- Muscle pains
- Knee pains
- back pain
- Muscle weakness
- Foot/ankle pains
- Hand/wrist pains
- Shoulder pain
- Hip pain
- ANY OTHER JOINT OR BONE PROBLEMS? _____

NEUROPSYCHOLOGICAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> 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: