Y. Clare Zhang Practice of Oriental Medicine

Health History Questionnaire

Date______________________

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire on both sides of each page carefully. All of your answers will be held confidential. Thank you.

Name________________________________ Date of Birth___________ Age_____ Height______ Weight______

☐ Male ☐ Female Relationship status ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Address____ City________________ State_____ Zip________

Home Phone_________________ Cell Phone_______________ Email ___________________________________

Occupation______________________ Employer__________________ Family Physician____________________

Emergency Contact________________________ Phone___________________ Relationship ___________________

How did you hear about us? ____________________ Who may we thank for referring you? ______________________

Have you been treated by Acupuncture or Chinese Medicine in the past? ☐ Yes ☐ No

Major concern(s) you would like help with (in order of significance) and how long they have lasted.

1. ____ 4.____
2. ____ 5. ____
3. ____ 6.____

How do these problems interfere with your daily activities? ____

____

Have you been given a diagnosis for these problems? If so, what? By whom?_____________________________________

____

What kinds of treatment have you tried?____

Results: ____

Past Medical History: (please include date)

☐ Cancer___________ ☐ High cholesterol_______ ☐ Autoimmune Diseases____
☐ Seizures__________ ☐ Diabetes ___________ ☐ Kidney Disease_________
☐ Stroke_____________ ☐ Thyroid Disease ______ ☐ Hepatitis______________
☐ Heart Disease_______ ☐ Asthma / Pneumonia ____ ☐ TB / Rheumatic Fever____
☐ High Blood Pressure______ ☐ Anemia ____________ ☐ Mononucleosis _________

Other (include chronic illnesses) ____

Surgeries (type and date)____

____

Significant trauma or hospitalizations (auto accidents, falls, concussions, etc.)_________________________________

____

Are you currently pregnant?_____________________________ If so, what is your due date?______________________

Family Medical History:

☐ Cancer________ ☐ High Blood Pressure_____ ☐ Asthma________
☐ Seizures_______ ☐ High Cholesterol________ ☐ Autoimmune Diseases___________
☐ Stroke_________ ☐ Diabetes_______________ ☐ Kidney Disease___________
☐ Heart Disease____ ☐ Thyroid Disease_________ ☐ Overweight __________

☐ Other____

Medications taken within the last three months (prescription and over the counter). Attach a list if needed.

1)____________________ 2)______________________ 3)________________________ 4)_________________________

5)____________________ 6)______________________ 7)________________________ 8)_________________________

Supplements (vitamins, herbs, minerals, etc.)____

Allergies (drugs, chemicals, foods) ____

What is your reaction? ____

Stress level (on a scale of 1-10) ________ Source of stress (work, family, relationship, chemical, physical, psychological, etc.) ____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe__________________________________

____

Have you ever been on a restricted diet? ☐ Yes ☐ No Please describe__________________________________

____

Please describe your intake of the following, per day. Cigarette ________ Second hand smoking (Y/N)___ Alcohol (which type)___________ Coffee________ Tea_________ Soda_________ Water_________ Milk________ Cheese________

Any use of drugs for non-medical purposes now or before ____

Please check and/or circle all the choices that apply to you in the following sections. Leave the Notes blank.

General / Overall Temperature

- ☐ Energy level (1 – 10)______
- ☐ Fatigue
- ☐ Localized weakness
  Where_________________
- ☐ Sudden energy drop in the day
  When___________
- ☐ Poor sleep
- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Cold hands / fingers / toes / feet
- ☐ Sweaty hands / feet

- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Spontaneous sweats
- ☐ Night sweats
- ☐ Hot flashes
  When_______________
- ☐ Heat in hands, feet & chest
- ☐ Feel thirsty easily
  When_______________
  Prefer warm or cold drink?
  Desire to drink when thirsty?
  Yes ___ No___

Notes

Pain

What makes the pain better?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Movement
- ☐ Rest
- ☐ Night
- ☐ Morning
- ☐ Afternoon

What makes the pain worse?

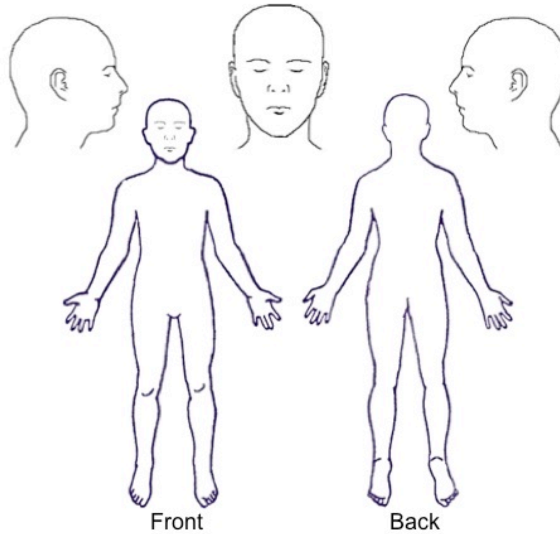
- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Movement
- ☐ Rest
- ☐ Night
- ☐ Morning
- ☐ Afternoon

Notes

Describe your pain:

- [ ] Sharp
- [ ] Burning
- [ ] Cramping, colicky
- [ ] Throbbing, bloating
- [ ] Dull, achy
- [ ] With a feeling of heaviness
- [ ] With a feeling of emptiness
- [ ] Fixed location
- [ ] Moving

Please mark clearly any areas of pain and indicate any scars.



Digestive Functions (Spleen, Stomach, Intestines)

- [ ] Poor appetite
- [ ] Abdominal bloating
- [ ] Gas
- [ ] Gurgling noise in abdomen
- [ ] Abdominal pain/cramp
- [ ] Nausea
- [ ] Vomiting
- [ ] Belching
- [ ] Indigestion
- [ ] Fatigue after eating
- [ ] Food allergies. What food?____

____

- [ ] Foods that give you trouble:

____

- [ ] Frequent thirst
- [ ] No thirst
- [ ] Prefer warm food & drink
- [ ] Prefer cold food & drink
- [ ] Bruise or bleed easily
- [ ] Organ prolapse. Which?______
- [ ] Hemorrhoids

- [ ] Over-thinking
- [ ] Worry

- [ ] Stools:
  - Frequency: _______times/day
  - Consistency:
    - Formed___ Hard___
    - Soft___ Loose___
- [ ] Diarrhea
- [ ] Loose Stools
- [ ] Undigested food in the stools
- [ ] Constipation
- [ ] Incomplete stools
- [ ] Blood in stools
- [ ] Mucus in stools

- [ ] Excessive appetite
- [ ] Feel hungry easily
- [ ] Heartburn
- [ ] Acid regurgitation
- [ ] Dry heaves
- [ ] Bad breath
- [ ] Canker sores in the mouth
- [ ] Bleeding, swollen, painful gums
- [ ] Gastric ulcer (diagnosed?)
- [ ] Stomach pain / discomfort
  - Better with: food___ cold___
  - warmth___ pressure___

Notes

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Respiratory Functions (Lung)

- [ ] Shortness of breath
- [ ] Low energy
- [ ] No or low desire to talk
- [ ] General weakness
- [ ] Feel worse after exercise
- [ ] Feel better after exercise
- [ ] Chronic fatigue & malaise
- [ ] Catch colds easily
- [ ] Sweat easily
- [ ] Difficulty breathing when lying
- [ ] Pneumonia (when___________)
- [ ] Bronchitis (when____________)
- [ ] Emphysema

- [ ] Sadness
- [ ] Melancholy
- [ ] Mourning for losses

- [ ] Allergies (to what?____________
- [ ] Asthma / wheezing
- [ ] Cough
- [ ] Production of phlegm
  Color: ________________
- [ ] Sinus congestion
- [ ] Nasal discharge (color________)
- [ ] Headache (where____________)
- [ ] Sore throat
- [ ] Swollen glands
- [ ] Overall ache in the body
- [ ] Stiff neck / shoulders
- [ ] Fever and chills
- [ ] Dry mouth
- [ ] Dry nose
- [ ] Dry skin
- [ ] Smoke cigarettes (# per day___

Notes

Sx

Cardiovascular Functions (Heart)

- [ ] Coronary artery disease
- [ ] Heart attack (when?__________)
- [ ] Stroke (when?______________)
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Chest discomfort / pain
- [ ] Heart palpitations
- [ ] Cold hands or feet
- [ ] Swelling of hands or feet
- [ ] Blood clots
- [ ] Anemia
- [ ] Feel better after exercise
- [ ] Other cardiovascular problems:
  ____
- [ ] Recurrent sores on the tongue

- [ ] Poor sleep
- [ ] Rested when waking up?
  Yes___ No___
- [ ] Difficulty falling asleep
- [ ] Waking at night (when________)
- [ ] Difficulty getting back to sleep
- [ ] Shallow sleep
- [ ] Vivid dreams
- [ ] Difficulty waking up
- [ ] Length of sleep (___ hours/day)

- [ ] Anxiety
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Poor memory

Notes

Head, Eyes, Ears, Nose & Throat

- [ ] Dizziness
- [ ] Headache
  Where___________________
  When____________________
  Type of pain_______________
- [ ] Poor vision
- [ ] Night blindness
- [ ] Cataract

- [ ] Poor hearing
- [ ] Ringing in ears
  Pitch: high___ low___
- [ ] Discharge from ears
- [ ] Earaches
- [ ] Recurrent sores in the mouth
- [ ] Recurrent sore throat
- [ ] Lump sensation in the throat

Notes

- [ ] Eye strain
- [ ] Eyes:
  red___ itchy___ watery___
  floaters___ gritty___ dry___
  blurry___ hot___ bloodshot__
- [ ] Nasal congestion / discharge
- [ ] Sinusitis / Rhinitis
- [ ] Gums bleed easily
- [ ] Grinding teeth at night
- [ ] Bad breath
- [ ] Peculiar taste in mouth
  Bitter___ Sour___ Sweet___
  Foul___ Other_________
- [ ] Abnormal / lack of taste

Liver & Gallbladder Functions

- [ ] Alternating loose stools & constipation
- [ ] Ribcage area pain / distension
- [ ] Tight sensation in the chest
- [ ] Bitter taste in the mouth
- [ ] Lump sensation in the throat
- [ ] Headache at the temples or top of the head
- [ ] Feel better after sighing
- [ ] Ringing in the ears
- [ ] Anger
- [ ] Depression
- [ ] Frustration
- [ ] Irritability
- [ ] Stressed easily
- [ ] History of emotional trauma
- [ ] Aversion to / Dislike wind
- [ ] Anemia
- [ ] Dizziness
- [ ] Poor sleep
- [ ] Many dreams
- [ ] Dry eyes / blurry vision
- [ ] Dry / pale / brittle nails
- [ ] Tingling sensation
- [ ] Numbness
- [ ] Muscle twitching
- [ ] Muscle spasms
- [ ] Neck / shoulder tension
- [ ] Seizures
- [ ] Convulsions
- [ ] Gall Stones (past or current)
- [ ] Alcohol intake / day _________
- [ ] Recreational drugs __________
- [ ] STD (which?_______________)

Notes

Kidney & Urinary Bladder Functions

- [ ] Frequent tooth problems
- [ ] Ringing in the ears
- [ ] Poor hearing
- [ ] Headache with an empty feeling
- [ ] Excessive hair loss
- [ ] Low back pain
- [ ] Weak / sore knees
- [ ] Feeling cold in the back / knees
- [ ] Swelling of ankles / feet
- [ ] Kidney stones
- [ ] Previous kidney diseases
  What?___________________
- [ ] History of bladder infections
- [ ] Lack of bladder control
- [ ] Wake during the night 2 or more times to urinate
- [ ] Fear
- [ ] Easily startled
- [ ] Urine color:
  Pale___ clear___
  Dark yellow___ Reddish___
  Cloudy___ Strong odor___
- [ ] Scanty urine
- [ ] Profuse urine
- [ ] Frequent urination
- [ ] Urgent urination
- [ ] Difficult urination
- [ ] Dribbling / incomplete urination
- [ ] Painful urination
  Type of pain______________
- [ ] Libido:
  High___ Low___
  Normal___

Notes

Output Input

Female Only

Age of first menstruation___________
Cycle between periods ____________days
Duration of periods ______________days
Age of menopause (if applicable)_____________

Number of pregnancies_____________
Number of births______________
Number of miscarriages________
Number of abortions___________

- ☐ Are you pregnant?
  Due date:_____________
- ☐ Irregular periods
  Range: ___________days
- ☐ Bleeding between periods
  Color_______ Volume_____
- ☐ Heavy periods
  Most heavy on Day_______
  (Day1: the 1st day of period.)
- ☐ Light periods
- ☐ Color of menses:
  normal red___ pale___
  bright red___ dark red___
  brown___ dark purple___
- ☐ Blood clots
  Size: Lg___ Med___ Sm___

- ☐ Painful periods
  Pain begins on Day _____
  Pain is severe on Days_____
  Type of pain: dull___ sharp___ cramp__
  Better with: heat___ cold___ pressure__
- ☐ Before or during the periods:
  Breast tender____ Hot sensation____
  Irritable____ Mood change____
  Skin problems____ Headache____
  Nosebleed____ Nausea____
  Mouth sores____ Loose stools____
  Fatigue____ Low back pain____
  Catch cold easily___ Water retention___
- ☐ Vaginal discharge
  Color: clear___ light yellow___ yellow__
  Strong odor___ Excessive amount___

Notes

Male Only

- ☐ Prostate hypertrophy
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Erectile dysfunction
- ☐ Testicular pain
- ☐ Low sexual energy
- ☐ Other?
  ____

Notes

Emotional State

Currently: ____________________________________
Significant past emotional experience:
____
____

Notes