Health History Questionnaire

Energetic Vision

230 N. 1680 E., Ste E2 ~ St. George, UT 84790
435-359-1479

Information for your Acupuncturist

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date: ____/____/____ Name: ____

Address: ______________________________ _ ____

City____State ____________ Zip______________

Email____

Home Phone: ________________________________ Work Phone: ____

Age: ______ Date of Birth: ____/____/____ Place of Birth: ____

Guardian (if under 18): ____

Gender: [ ] M [ ] F Height: ____'____" Weight: ________lbs.

Occupation: __________________________________Employer: ____

How did you hear about our office? ____

Primary Care Physician: ____

Emergency Contact:________________________________Relationship:___________________________________

Phone:____________________________________Cell/Work Phone:______________________________________

Medications (Prescription & Over-the-counter): ____

____

Western Medical Eye Diagnosis ____

Other Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Date of onset	
1.	☐	☐	☐	__________	______________________________
2.	☐	☐	☐	__________	______________________________
3.	☐	☐	☐	__________	______________________________
4.	☐	☐	☐	__________	______________________________
5.	☐	☐	☐	__________	______________________________
6.	☐	☐	☐	__________	______________________________

Family History:

Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	Sisters	Child	Spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age of death						
Cause of death						
Cancer						
Diabetes						
Heart Disease/ High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Other:						

Supplements (if any vitamins, herbs, minerals, etc): ______________________________

____

Allergies:
Are you hypersensitive or allergic to?
Any drugs? ☐☐ Yes ☐☐ No Please list:______________________________
Any foods? ☐☐ Yes ☐☐ No Please list:______________________________

Symptom Profile

For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Acne, Boils	☐	☐	______
Acute Hair Loss	☐	☐	______
Eczema, Hives	☐	☐	______
Nail Fungus	☐	☐	______
Rash	☐	☐	______
Surgery's	☐	☐	______
Scars	☐	☐	______
Other______	☐	☐	______

Respiratory System Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Bronchitis	☐	☐	______
Chronic Asthma	☐	☐	______
Chronic Cough	☐	☐	______
Emphysema	☐	☐	______

Frequent Colds	☐	☐	______________
Pain in Breathing	☐	☐	______________
Pleurisy	☐	☐	______________
Pneumonia	☐	☐	______________
Shortness of Breath	☐	☐	______________
Sinus Congestion	☐	☐	______________
Spitting up Blood	☐	☐	______________
Temporary Cough	☐	☐	______________
Tuberculosis	☐	☐	______________
Nasal drainage	☐	☐	______________
Other____________	☐	☐	______________

Emotional or Mental Illness:

Currently have?	**YES**	**PAST**	**WHEN?**
Anxiety	☐	☐	______________
Depression	☐	☐	______________
Considered or Attempted Suicide	☐	☐	______________
Irritability	☐	☐	______________
Mood Swings	☐	☐	______________
Other____________	☐	☐	______________

Head, Ear, Eyes, Nose, Throat:

Currently have:	**YES**	**PAST**	**WHEN?**
Headaches	☐	☐	______________
Migraines	☐	☐	______________
Head Injury	☐	☐	______________
Hay Fever	☐	☐	______________

Ears:	**YES**	**PAST**	**WHEN?**
Earaches	☐	☐	______________
Ringing in Ears	☐	☐	______________
Impaired Hearing	☐	☐	______________
Dizziness	☐	☐	______________

Eyes:	**YES**	**PAST**	**WHEN?**
Cataracts	☐	☐	______________
Color Blindness	☐	☐	______________
Contacts or Glasses	☐	☐	______________
Double Vision	☐	☐	______________
Eye Pain or Strain	☐	☐	______________
Glaucoma	☐	☐	______________
Impaired Vision	☐	☐	______________
Tearing or Dryness	☐	☐	______________
Spots in Front of Eyes	☐	☐	______________
Retinal Disease	☐	☐	______________

Nose:	**YES**	**PAST**	**WHEN?**
Nose Bleeds	☐	☐	______________
Loss of Smell	☐	☐	______________

Mouth:	**YES**	**PAST**	**WHEN?**
Bleeding Gums	☐	☐	______________
Dental Cavities	☐	☐	______________
Dry Mouth	☐	☐	______________
Oral Sores	☐	☐	______________
Oral Thrush	☐	☐	______________
Teeth Grinding	☐	☐	______________
Jaw Problems, TMJ	☐	☐	______________

Throat:

Currently have?	**YES**	**PAST**	**WHEN?**
Goiter	☐	☐	______________
Hoarseness	☐	☐	______________
Swollen Glands	☐	☐	______________
Trouble Swallowing	☐	☐	______________
Neck Pain/Stiffness	☐	☐	______________
Frequent Sore Throat	☐	☐	______________
Other____________	☐	☐	______________

Digestive Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Nausea	☐	☐	______________
Vomiting	☐	☐	______________
Loss of Appetite	☐	☐	______________
Ulcer	☐	☐	______________
Heartburn	☐	☐	______________
Gas or bloating	☐	☐	______________
Internal Cramping	☐	☐	______________
Constipation	☐	☐	______________
Diarrhea	☐	☐	______________
Loose Stool	☐	☐	______________
Hemorrhoids	☐	☐	______________
Bowel Movement Frequency?			______________
Is this a change?			______________
Other____________	☐	☐	______________

Cardiovascular Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Heart Disease	☐	☐	______________
Endocarditis	☐	☐	______________
Chest Pain	☐	☐	______________
Heart Murmur	☐	☐	______________
Palpitations or fluttering	☐	☐	______________
High Blood Pressure	☐	☐	______________
Low Blood Pressure	☐	☐	______________
Phlebitis	☐	☐	______________
Blood Clots	☐	☐	______________
Ankle Swelling	☐	☐	______________
Fainting	☐	☐	______________
Other____________	☐	☐	______________

Urinary Tract Disorders:

Currently have?	**YES**	**PAST**	**WHEN?**
Frequent infection	☐	☐	______________
Frequent Night Urination	☐	☐	______________
Inability to hold urine	☐	☐	______________
Burning or pain during urination	☐	☐	______________
Increased frequency	☐	☐	______________
Kidney stones	☐	☐	______________

Other____________ ☐ ☐ _____________

Musculoskeletal Disorders:

Currently have?	YES	PAST	WHEN?
Weakness	☐	☐	_____________
Muscle Spasms or cramps	☐	☐	_____________
Joint pain, swelling, or stiffness	☐	☐	_____________
Sciatica	☐	☐	_____________
Fibromyalgia	☐	☐	_____________
Broken bones	☐	☐	_____________
Any other pain	☐	☐	_____________

Location:____

Other___________ ☐ ☐ _____________

Miscellaneous:

Currently have?	YES	PAST	WHEN?
Easy bleeding or bruising	☐	☐	_____________
Varicose veins	☐	☐	_____________
Anemia	☐	☐	_____________
Slow wound healing	☐	☐	_____________
Chronic infections	☐	☐	_____________
Day sweats	☐	☐	_____________
Night sweats	☐	☐	_____________
Cold hands or feet	☐	☐	_____________
Heat or cold intolerance	☐	☐	_____________
Fatigue	☐	☐	_____________
Chronic fatigue syndrome	☐	☐	_____________
Hypoglycemia	☐	☐	_____________
Hyperthyroid	☐	☐	_____________
Hypothyroid	☐	☐	_____________
Excessive Thirst	☐	☐	_____________
Excessive hunger	☐	☐	_____________
Diabetes	☐	☐	_____________
Gallbladder disease	☐	☐	_____________
Liver disease	☐	☐	_____________
Jaundice	☐	☐	_____________
Hepatitis	☐	☐	_____________

Type?____

Other____________ ☐ ☐ _____________

Lifestyle Habits:

Do you…

Exercise? ☐ No ☐Yes

What kind?_____________________________

How often?_____________________________

Take vacations? ☐ No ☐Yes

How often?_____________________________

Tobacco, food and drink habits:

Do you…

Use tobacco ☐ No ☐Yes

How much/how often?__________________

Smoked previously? ☐ No ☐Yes

How long?_____________________

How many packs a day?_________________

Ever been treated for drug dependence? ☐ No ☐Yes

Drink Alcohol? ☐ No ☐Yes

How much/often?__________________

Drink caffeinated beverages? ☐ No ☐Yes

How much/often?__________________

Eat out? ☐ No ☐Yes

Times per week?___________________

Sleep habits:

Do you…

Sleep well? ☐ No ☐Yes

Awaken rested ☐ No ☐Yes

Average 6-8 hrs. sleep ☐ No ☐Yes

Spend time outside ☐ No ☐Yes

What time of day is your energy at its best?________

How many meals to you eat per day?_______

Go on diets often? ☐ No ☐Yes

Typical food intake:

Breakfast_________________________________

____

Lunch____________________________________

____

Dinner___________________________________

____

Snacks___________________________________

____

Which selection most closely describes your diet? (You may check more than one item)

☐ Vegan ☐ Raw Foods ☐ Vegetarian ☐ Mostly Vegetarian ☐ Low fat ☐ Low carb ☐ Allergy conscious
☐ Fast food/restaurants ☐ Ethnic ☐ Typical American

Which of these selections do you take daily (3 checks), several times a week (2 checks), once a week (1 check):

Sugar_____ Sugar substitutes_____ Coffee_____ Tobacco_____ Red Meat_____ Alcohol_____ Diet drinks_____

Any history of psychological, physical or sexual abuse? ☐ No ☐Yes

____

FOR MEN ONLY:

Do you now, or have you ever had…?

Testicular masses	☐ No	☐Yes	When?____________________
Testicular pain	☐ No	☐Yes	When?____________________
Prostate Disease	☐ No	☐Yes	When?____________________
Impotence	☐ No	☐Yes	When?____________________
Premature ejaculation	☐ No	☐Yes	When?____________________
Hernias	☐ No	☐Yes	When?____________________
Syphilis	☐ No	☐Yes	When?____________________
Genital, oral or rectal herpes	☐ No	☐Yes	When?____________________
Gonorrhea	☐ No	☐Yes	When?____________________
Other______________	☐ No	☐Yes	When?____________________

FOR WOMEN ONLY:

Do you now, or have you ever had…?

Breast lumps	☐ No	☐Yes	When?____________________
Nipple discharge	☐ No	☐Yes	When?____________________
Breast pain or tenderness	☐ No	☐Yes	When?____________________
Abnormal PAP smear	☐ No	☐Yes	When?____________________
Cervical dysplasia	☐ No	☐Yes	When?____________________
Vaginal discharge	☐ No	☐Yes	When?____________________
Gonorrhea	☐ No	☐Yes	When?____________________
Syphilis	☐ No	☐Yes	When?____________________
Genital, oral or rectal herpes	☐ No	☐Yes	When?____________________
Fibroids	☐ No	☐Yes	When?____________________
Ovarian cysts	☐ No	☐Yes	When?____________________
Sexual difficulties	☐ No	☐Yes	When?____________________
Are you on birth control?	☐ No	☐Yes	When?____________________

Number of pregnancies ______________

Number of live births ______________

Number of miscarriages ______________

Number of abortions ______________

Age at first menses ______________

Length of cycle in days ______________

Duration of period in days______________

PMS symptoms	☐ No	☐Yes	When?____________________
Painful menses	☐ No	☐Yes	When?____________________
Clotting during menses	☐ No	☐Yes	When?____________________
Bleeding between periods	☐ No	☐Yes	When?____________________
Menopausal symptoms	☐ No	☐Yes	When?____________________
Other_____________	☐ No	☐Yes	When?____________________