point flow
acupuncture

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	
Address		**City**	**State**	**Zip**
Phone	**Home**	**Work**	**Cell**	
Email				
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
FAMILY PHYSICIAN			**Date of last Physical exam:**	

PERSONAL HEALTH HISTORY

Reason for Today's visit

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, vitamins, supplements, herbs

Name	Strength/Dose	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS						
	# of meals you eat in an average day?		What time do you eat your first meal?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
					☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Health Issues

Check if you have had any symptom in the following areas to a significant degree and briefly explain

Skin/Hair	☐ Emphysema	**Muscle and joint**
☐ Rashes	**Cardio-vascular**	☐ Stiff neck
☐ Itching	☐ Palpitations	☐ Back pain
☐ Hives	☐ High Blood Pressure	☐ Scoliosis
☐ Eczema	☐ Low blood pressure	☐ Herniated disc
☐ Psoriasis	☐ Poor circulation	☐ Arthritis
☐ Hair Loss	☐ Heart disease	☐ Swollen/stiff joints
Head, Eyes, Ears, Nose, Throat	☐ By-pass surgery	☐ Sciatica
☐ Thyroid Disease	☐ Varicose veins	☐ Weak muscles
☐ Concussions	☐ Spider veins	☐ Numbness or tingling
☐ Migraines	☐ Myocardial infarction	☐ Plantar Fascitis
☐ Eye Pain	**Gastrointestinal**	**General symptoms**
☐ Blurry Vision	☐ Poor appetite	☐ Tremors
☐ Cataracts	☐ Excessive hunger	☐ Fever
☐ Earaches	☐ Belching	☐ Fainting
☐ Ringing in the ears	☐ Gas	☐ Dizziness
☐ Poor hearing	☐ Bloating	☐ Convulsion
☐ Sinus problems	☐ Vomiting	☐ Sleeping problems
☐ Recurrent sore throats	☐ Colitis	☐ Fatigue
☐ Nose Bleeds	☐ Irritable Bowel Syndrome	☐ Depression
☐ Grinding Teeth	☐ Constipation	☐ Anxiety
☐ Sores on lips or tongue	☐ Diarrhea	☐ Confusion
☐ Facial pain	☐ Liver disease	
☐ Teeth problems	☐ Gallbladder disease	
☐ TMJ/jaw problems	☐ Jaundice	
☐ Headaches	**Genitourinary**	
Respiratory	☐ Frequent urination	
☐ Chronic cough	☐ Scanty urine	
☐ Spitting up phlegm/blood	☐ Painful urination	
☐ Chest pain	☐ Blood in urine	
☐ Difficulty breathing	☐ Cloudy urine	
☐ Shortness of breath	☐ Recurrent bladder/Kidney infections	
☐ Wheezing	☐ Kidney stones	
☐ Asthma	☐ Inability to control urine	

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No