TURTLE DRAGON
HEALTH SERVICES

Health History Questionnaire

Date _____

Name _____ Birth Date _____

Home Phone _____ Work Phone _____ Email _____

Street Address _____ City _____ State ____ Zip _____

Place of Birth _____ Height _____ Weight _____ Age _____ Marital Status _____

Occupation _____ Family Physician _____ Referred By _____

Emergency Contact Name and Phone _____

Have You Had Acupuncture Before? Yes / No (circle one)

Main Complaint

_____

How Long Ago Did this Begin? _____ Known Cause? _____

_____

To what extent does this interfere withyour daily activities (work, sleep, sex, etc.)?

_____

Have you been given a diagnosis for this condition? If so, what?

_____

What kind(s) of treatment have you tried?

Past Medical History *(please check all that apply)*

- ◯ Cancer
- ◯ Arthritis
- ◯ High Blood Pressure
- ◯ Diabetes
- ◯ Breathing Problems
- ◯ High Cholesterol
- ◯ Hepatitis
- ◯ Heart Disease
- ◯ Venereal Disease
- ◯ Alcoholism
- ◯ Emotional Disorders
- ◯ Seizures
- ◯ Depression or Anxiety
- ◯ Thyroid Disease
- ◯ Digestive Disorders
- ◯ Other _____

Surgeries or Hospitalization

Significant Trauma _____

Allergies (drugs, chemicals, foods): _____

Birth History (i.e. prolonged labor, forceps delivery): _____

Occupation

Occupational Stress (chemical, physical, psychological): _____

Do You Have a Regular Exercise Program? Please describe

_____

_____

Medicines

Please List All Medications Taken Within the Last Two Months (include vitamins, over-the-counter drugs, herbs, etc.)

_____

_____

_____

Diet and Nutrition

Are you or Have You Ever Been on a Restricted Diet? What Kind?

_____

Please Describe Your Average Daily Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

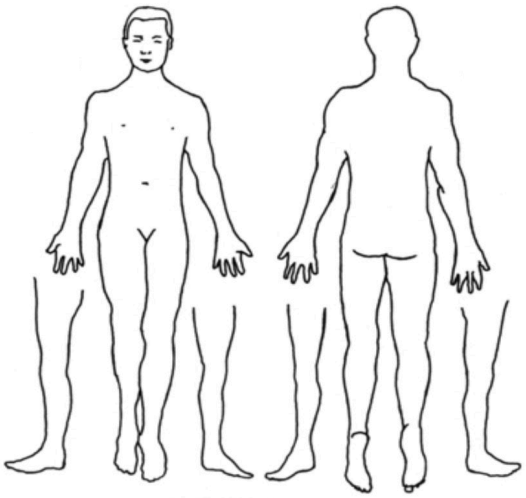
Snack: _____

How Many Cigarettes Do You Smoke Per Day?

How Much Coffee, Tea or Soda Do You Drink Per Week?

Please Describe Any Use of Drugs for Non-Medical Purposes: _____

Indicate Painful or Distressed Areas



Please Check if You Have or Have Had Any of the Following in the Past Three Months

General

- ◯ Night sweats
- ◯ Sweat easily
- ◯ Fevers
- ◯ Chills
- ◯ Fatigue
- ◯ Change in appetite
- ◯ Poor appetite
- ◯ Peculiar tastes
- ◯ Cravings
- ◯ Desire hot/cold food
- ◯ Strong thirst hot/cold
- ◯ Weight loss/gain
- ◯ Bleed or bruise easily
- ◯ Poor balance
- ◯ Tremors
- ◯ Local weakness
- ◯ Sudden energy drop
  (What time of day?) _____

Skin and Hair

- ◯ Rashes
- ◯ Itching
- ◯ Pimples
- ◯ Acne
- ◯ Hives
- ◯ Eczema
- ◯ Loss of Hair
- ◯ Ulcerations
- ◯ Dandruff
- ◯ Dry skin
- ◯ Recent moles
- ◯ Any other hair or skin changes/problems?

  _____

Head, Eyes, Ears, Nose, Throat

- ◯ Dizziness
- ◯ Concussions
- ◯ Migraines
- ◯ Glasses
- ◯ Poor vision
- ◯ Headaches
  (Where?) _____
- ◯ Cataracts
- ◯ Eye pain
- ◯ Eye strain
- ◯ Night blindness
- ◯ Color blindness
- ◯ Blurry vision
- ◯ Earaches
- ◯ Ringing in ears
- ◯ Poor hearing
- ◯ Spots in front of eyes
- ◯ Sinus problems
- ◯ Nose bleeds
- ◯ Recurrent sore throat
- ◯ Grinding teeth
- ◯ Facial pain
- ◯ Teeth problems
- ◯ Jaw clicks
- ◯ Sores on lips or tongue
- ◯ Other head or neck problems?

  _____

Cardiovascular

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Irregular heartbeat
- ◯ Blood clots
- ◯ Dizziness
- ◯ Swelling of hands
- ◯ Chest pain
- ◯ Fainting
- ◯ Swelling of feet
- ◯ Difficulty in breathing Phlebitis
- ◯ Cold hands or feet

Respiratory

- ◯ Cough
- ◯ Bronchitis
  Difficulty breathing while lying down? Yes / No
- ◯ Coughing blood
- ◯ Pneumonia
- ◯ Asthma
- ◯ Phlegm
  What color? _____
- ◯ Pain with deep breath
- ◯ Chest pain
- ◯ Wheezing

Gastrointestinal

- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Gas
- ◯ Belching
- ◯ Black stools
- ◯ Blood in stools
- ◯ Indigestion
- ◯ Bad breath
- ◯ Rectal pain
- ◯ Hemorrhoids
- ◯ Abdominal pain or cramps
- ◯ Chronic laxative use
- ◯ Parasites
- ◯ Other problems? _____

Bowel movements: Frequency _____ Color _____ Texture/Form _____ Strong odor Yes / No

Genitourinary

- ◯ Pain on urination
- ◯ Urgency to urinate
- ◯ Decrease in flow
- ◯ Frequent urination
- ◯ Urine incontinence
- ◯ Color of urine? _____
- ◯ Blood in urine
- ◯ Kidney stones
- ◯ Impotency
- ◯ Sores on genitals

Do you wake to urinate? Yes / No How often? _____

Neuropsychological

- ◯ Depression
- ◯ Concussion
- ◯ Anxiety
- ◯ Stress
- ◯ Bipolar
- ◯ Seizures
- ◯ Irritability
- ◯ Numbness
- ◯ Lack of coordination
- ◯ Loss of balance

Have you ever had emotional problems? Yes / No Please explain _____

_____

Have you ever attempted suicide? Yes / No

Any other neruological or psychological problems? Yes / No Please list _____

_____

Pregnancy and Gynecology

Number of pregnancies _____
Number of births _____
Miscarriages _____
Abortions _____

Premature births _____
Age of first menses _____
Days between periods _____
Duration of period _____

First day of last period _____
Last PAP _____

- ◯ Breast lumps
- ◯ Vaginal infections
- ◯ Vaginal discharge
- ◯ Breast tenderness
- ◯ Pelvic infection
- ◯ Infertility
- ◯ Hot flashes
- ◯ Fibroids
- ◯ Endometriosis
- ◯ Ovarian cysts
- ◯ Painful period
- ◯ Irregular period
- ◯ Clots
- ◯ Unusual character? Heavy / Light
- ◯ Birth control use? How long? _____

Changes in body/psyche prior to period? Yes / No Please explain _____