

Five Seasons Women's Wellness  
Ariel Solomon, L.Ac.  
**HEALTH HISTORY QUESTIONNAIRE**

**Important:** The information on this form will help your health care provider to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition they may play a contributing or underlying role in diagnosis and treatment of your problem.

*All information gathered is strictly confidential*

**GENERAL PATIENT INFORMATION**

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ E-Mail (optional): \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Married Separated Divorced Single Domestic Partner Other \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_

Name of your primary health care provider: \_\_\_\_\_

Date of most recent visit: \_\_\_\_\_ Reason for that visit: \_\_\_\_\_

Do you have insurance? Y N Do you plan on using it for your acupuncture? Y N

How did you hear about our office? \_\_\_\_\_ (if internet, what website? \_\_\_\_\_)

Have you had acupuncture before? Y N For what? \_\_\_\_\_

Did the acupuncture help? \_\_\_\_\_

Condition(s) you are seeking acupuncture for, in order of significance to you:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_ (4) \_\_\_\_\_

Please explain how this condition(s) affects your daily life: \_\_\_\_\_

Do you know what is causing this problem(s)? \_\_\_\_\_

What treatment(s) have you tried? \_\_\_\_\_

List any other conditions or complaints that you would like us to know about: \_\_\_\_\_

What are 5 things that you know you could do to improve your health? (1) \_\_\_\_\_

(2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_

What is preventing you from doing these things? \_\_\_\_\_

On a scale of 1-10, how committed are you to improving your health? (Circle one) 1 2 3 4 5 6 7 8 9 10

Do you follow any special diet? \_\_\_\_\_

Do you exercise regularly? Y N What type? \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

**FAMILY HISTORY:**

	Self	Mother	Father	Sister	Brother	Spouse	Child
Cancer							
Heart disease							
High blood pressure							
Stroke							
Diabetes							
Kidney or bladder disorder							
Stomach or intestinal disorder							
Substance abuse							
Depression/ mental illness							
Other							

**MAJOR HOSPITALIZATIONS:**

Illness or Operation	Year

**PATIENT PROFILE**

Current medications (prescription and over the counter): \_\_\_\_\_

Current herbs/ supplements/ vitamins: \_\_\_\_\_

Allergies: \_\_\_\_\_

**HABBITS:**

Coffee Y N use per day/ week \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_

Tobacco Y N use per day/ week \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_

Alcohol Y N use per day/ week \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_

Other Y N use per day/ week \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_

**PAIN:**

Do you have any chronic pain? Yes No, if yes, describe \_\_\_\_\_

For how long? \_\_\_\_\_

What makes it better/ worse? \_\_\_\_\_

**GENERAL**

Past/ Present

- Poor appetite
- Excessive appetite
- Insomnia
- Fatigue
- Night sweats
- Sweats easily
- Chills
- Localized weakness
- Change in appetite
- Diabetes
- Other \_\_\_\_\_

**SKIN AND HAIR**

Past/ Present

- Rashes/ hives
- Itching
- Eczema
- Pimples
- Dryness
- Lump/ tumor
- Other \_\_\_\_\_

**HEAD AND NECK**

Past/ Present

- Dizziness
- Fainting
- Neck stiffness
- Enlarged lymph glands
- Headaches
- Migraines
- Convulsions
- Other \_\_\_\_\_

**EYES**

Past/ Present

- Blurred vision
- Poor night vision
- Spots
- Cataracts
- Glasses/ Contacts
- Eye inflammation
- Visual changes
- Other \_\_\_\_\_

**NOSE, THROAT, MOUTH**

Past/ Present

- Nose bleeds
- Sinus infection
- Allergies/ hay fever
- Recurring sore throats
- Grinding teeth
- Difficulty swallowing
- Other \_\_\_\_\_

**EARS**

Past/ Present

- Decreased Hearing
- Frequent Infection
- Deafness
- Other \_\_\_\_\_

**CARDIOVASCULAR**

Past/ Present

- Diabetes
- High/ Low blood pressure
- Bleeding Disorder
- Blood clots
- Palpitations
- Fainting
- Phlebitis
- Chest pain
- Irregular heart beat
- Cold hands/feet
- Swelling of hands/ feet
- Heart disease
- CVA (stroke)
- Vein condition
- Other \_\_\_\_\_

**RESPIRATORY**

Past/ Present

- Asthma
- Bronchitis
- Frequent colds
- COPD
- Emphysema
- Pneumonia
- Cough
- Coughing blood
- Production of phlegm
- Other \_\_\_\_\_

**GASTRO-INTESTINAL**

Past/ Present

- Nausea
- Vomiting
- Diarrhea
- Belching
- Blood in stool/ black stool
- Bad breath
- Rectal pain
- Hemorrhoids
- Constipation
- Pain or cramps
- Indigestion
- Gall bladder disorder
- Gas
- Other \_\_\_\_\_

**GENITO-URINARY**

Past/ Present

- Kidney stones
- Pain on urination
- Frequent urination
- Blood in urine
- Urinary urgency
- Inability to hold urine
- Other \_\_\_\_\_

**NEUROLOGICAL**

Past/ Present

- Seizures
- Tremors
- Numbness or tingling of limbs
- Concussion
- Pain
- Paralysis
- Other \_\_\_\_\_

**PSYCHOLOGICAL**

Past/ Present

- Depression
- Anxiety
- Stress
- Irritability
- Treated for emotions/ psychological problems
- Other \_\_\_\_\_

**INFECTIONS**

Past/ Present

- HIV/ AIDS
- TB
- Hepatitis
- Gonorrhea
- Chlamydia
- Genital warts
- Herpes: oral or genital
- Syphilis
- Other \_\_\_\_\_

**WOMEN'S HEALTH**

- |  |   |   |
|--|---|---|
| Past/ Present  | Past/ Present   | Past/ Present   |
| <input type="checkbox"/> <input type="checkbox"/> Frequent UTI               | <input type="checkbox"/> <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Frequent infection         | <input type="checkbox"/> <input type="checkbox"/> Abnormal pap smear          | <input type="checkbox"/> <input type="checkbox"/> Breast lumps      |
| <input type="checkbox"/> <input type="checkbox"/> Pain/ Itching of genitalia | <input type="checkbox"/> <input type="checkbox"/> Irregular periods           | <input type="checkbox"/> <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> <input type="checkbox"/> Vaginal lesions/ discharge | <input type="checkbox"/> <input type="checkbox"/> Painful periods             | <input type="checkbox"/> <input type="checkbox"/> Other_____        |
| <input type="checkbox"/> <input type="checkbox"/> Vaginal Dryness            | <input type="checkbox"/> <input type="checkbox"/> PMS                         |   |

Are you pregnant? Y N (please notify your acupuncturist if you become or are planning on becoming pregnant)

Total pregnancies\_\_\_\_\_ Live births\_\_\_\_\_ Ectopic\_\_\_\_\_ Miscarriages\_\_\_\_\_ Induced Abortions\_\_\_\_\_

**MENSTRUATION:**

Average # of days of flow:\_\_\_\_\_ Average # of days of entire cycle:\_\_\_\_\_ Age of first menstruation:\_\_\_\_\_

Please fill in the following menstrual chart based on your typical period:

	Before	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	After
Color (normal, bright red, pale, brown, rust, dark, purple...)									
Amount of flow (moderate, heavy, light)									
Pain/cramps (location, dull, sharp...)									
Clots (large, small, black, purple, red...)									
Other (please specify)									

**MENOPAUSE:** Y N

Approximate date of onset:\_\_\_\_\_ Bleeding Since? Y N If yes, explain:\_\_\_\_\_

Current associated symptoms:\_\_\_\_\_

**MEN'S HEALTH**

- |  |  |   |
|--|--|---|
| Past/ Present  | Past/ Present  | Past/ Present   |
| <input type="checkbox"/> <input type="checkbox"/> Pain/ Itching of genitalia | <input type="checkbox"/> <input type="checkbox"/> Nocturnal emission       | <input type="checkbox"/> <input type="checkbox"/> Feeling of coldness or numbness in external genitalia |
| <input type="checkbox"/> <input type="checkbox"/> Genital lesions/ discharge | <input type="checkbox"/> <input type="checkbox"/> Early ejaculation        | <input type="checkbox"/> <input type="checkbox"/> Difficulty getting of maintaining an erection         |
| <input type="checkbox"/> <input type="checkbox"/> Impotence                  | <input type="checkbox"/> <input type="checkbox"/> Thick/ dense semen       | <input type="checkbox"/> <input type="checkbox"/> Infertility   |
| <input type="checkbox"/> <input type="checkbox"/> Weak urinary stream        | <input type="checkbox"/> <input type="checkbox"/> Discolored/ yellow semen |   |
| <input type="checkbox"/> <input type="checkbox"/> Enlarged prostate          | <input type="checkbox"/> <input type="checkbox"/> Spermatorrhea            |   |
| <input type="checkbox"/> <input type="checkbox"/> Lumps in testicles         |  |   |
| <input type="checkbox"/> <input type="checkbox"/> Other_____                 |  |   |

**ADDITIONAL COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature:\_\_\_\_\_

Ariel Solomon, L.Ac.:\_\_\_\_\_