

Five Seasons Women's Wellness
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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: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ E-Mail (optional): _____

How would you like to be contacted for appointment reminders? Phone (which? _____) E-Mail

Age: _____ Date of Birth: ___/___/___ Gender: _____ Height: ___'___" Weight: _____ lbs.

Soc. Sec. #: _____ - _____ - _____ 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? _____

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
- Strong thirst
- 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

- High blood pressure
- Low blood pressure
- 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 breathe
- 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.:_____