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Patient Health History

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark.

Thank You.

1. Are you currently receiving health care? Y N If yes, where and from whom? ___________________________

   ____

   If no, when and where did you last receive health care? _____________________________ For what reason?__________________

2. Please Identify below the health concerns that have brought you to Alpine Acupuncture, LLC:

   Condition **Past Treatment**

   a. ______________________________________ ____

      How does this condition affect you? ____

   b. ______________________________________ ____

      How does this condition affect you? ____

   c. ______________________________________ ____

      How does this condition affect you? ____

   d. ______________________________________ ____

      How does this condition affect you? ____

   e. ______________________________________ ____

      How does this condition affect you? ____

3. What are your most important health problems? Please list in order of importance:

   a. ____ b. ____

   c. ____ d. ____

4. Do you have any reason to believe that you are pregnant? Y N

5. Do you have any chronic infectious diseases? Y N If yes, please explain: _______________________________

6. Are you currently suffering from any chronic illness? Y N If yes, please explain: _______________________________

7. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

____

8. Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking:

____ ____

____ ____

____ ____

9. Height: ________ Weight: Currently: ___________ Past Maximum Weight: ______________ When?______________________

10. Blood Pressure: What is your most recent blood pressure reading? / When was this reading taken? _________

11. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Immunizations (Please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria

Others: ____

13. Hospitalizations and Surgeries:

Reason	When	Reason	When

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When

15. Family History:

	Mother	Father	Brother(s)	Sister(s)	Spouse	Children
Age if Living:	____	____	____	____	____	____________
Health (Good = G, Poor = P):	____	____	____	____	____	____________
Age at death (if deceased):	____	____	____	____	____	____________
Cause of death:	____	____	____	____	____	____________

Please circle any of the following conditions that members of your family have had:

Cancer Diabetes Heart Disease High Blood Pressure Stroke Mental Illness

Please circle any of the following conditions that you experience now and underline any that you have experienced in the past.

16. Emotional:

Mood Swings Nervousness Mental Tension

17. Energy and Immunity:

Fatigue Slow Wound Healing Chronic InfectionsChronic Fatigue Syndrome

18. Head, Eye, Ear, Nose, and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

19: Respiratory:

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: ____

20. Cardiovascular:

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

21. Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Stool: Diarrhea Constipation Undigested Food Mucous Blood in Stool

22. Genito-Urinary Tract:

Kidney Disease Painful Urination Frequent Urinary Tract Infections Frequent Urination

Venereal Disease Kidney Stones Impaired Urination Frequent Urination at Night Blood in Urine

23. Male Reproductive:

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

24. Menstrual/Birthing History:

1. Age of First menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _______
4. Birth Control: ___________
5. # of Pregnancies: ________
6. # of Miscarriages: ______
7. # of Abortions: __________
8. # of Live Births: __________
9. Surgeries (GYN): ______

25. Female Reproductive/Breasts:

PMS   Irregular Cycles   Heavy Flow   Clotting   Bleeding Between Cycles   Vaginal Discharge

Breast Lumps/Tenderness   Nipple Discharge   Difficulty Conceiving   Menopausal Symptoms

26. Neurological/Musculoskeletal:

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain

Low Back Pain   Leg Pain   Joint Pain (if so, where?): ________________________________

27. Endocrine:

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

28. Other:

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

Is there anything else we should know?____

29. Lifestyle:

a. Please indicate typical food intake:

Breakfast: ______________________ Lunch: ______________________

Dinner:______________________ Snacks: ______________________

b. Daily Exercise:____

c. Spiritual Practice:____

d. Sleep Habits: ____

e. Education: ____

f. Occupation: ____________________ Employer: ____________________ Hours/Week:______

Do you enjoy Work?   Y   N   Why/Why not? ______________________________

g. Nicotine/Alcohol/Caffeine Use: ____

h. Have you experienced any major traumas?   Y   N   Explain: ______________________

i. Interests and Hobbies:____