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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? _____

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 Infections Chronic 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: _____ 3. Length of Cycle:_____ 4. First Day of Last menses: _____

5. # of Pregnancies: _____ 6. # of Births:_____ 7. # of Abortions: _____ 8. # of Miscarriages:_____

9. Birth Control History:_____ 10. 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: _____