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Health History Questionnaire

**Please use the reverse of these sheets if needed for more detailed information.
Please bring copies of relevant labs, test results/reports, etc. to your initial visit.

Patient's Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Age today: _____ Place of Birth: _____ Gender: (M / F)

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

*Is it OK to leave messages? Yes / No Fax: _____ Email: _____

Employment Status _____ Occupation: _____

Employer / School: _____

Marital status: _____ Partner's name: _____ # of Children _____

Current Height _____ Current Weight _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency Contact Address: _____

CURRENT MEDICAL INFORMATION:

Allergies (drugs, chemicals, animals, etc.) Please describe what reactions you have to allergens: _____

CURRENT PRESCRIPTION MEDICATIONS:

Name of Medication	Condition treating	Date first prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUPPLEMENTS, HERBS, VITAMINS, OVER THE COUNTER MEDICATIONS:

Name	Condition treating	Duration of use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Critical Information: (i.e. pacemaker, etc.) _____

Patient's Name: _____

Today's Date: ____ / ____ / ____

What is your main concern today? Have you been given a Western Medical diagnosis? (describe)

When did this issue begin? What do you feel was the cause of this issue? Is the cause still present? (Please be specific)

What treatments have you tried? What other types of practitioners have you seen? What were the results?

How would your life be different if this concern were no longer present? What would your life look like? What would you do differently? _____

What is the intensity of your concern right now? *Please rate on a scale of 1-10, 1=barely notice 10=unbearable.*

1 2 3 4 5 6 7 8 9 10

What makes your condition better? _____

What makes your condition worse? _____

Have you noticed any other correlations (i.e. changes with weather, stress, emotions)? _____

Are there other concerns you would like to focus on with treatment? _____

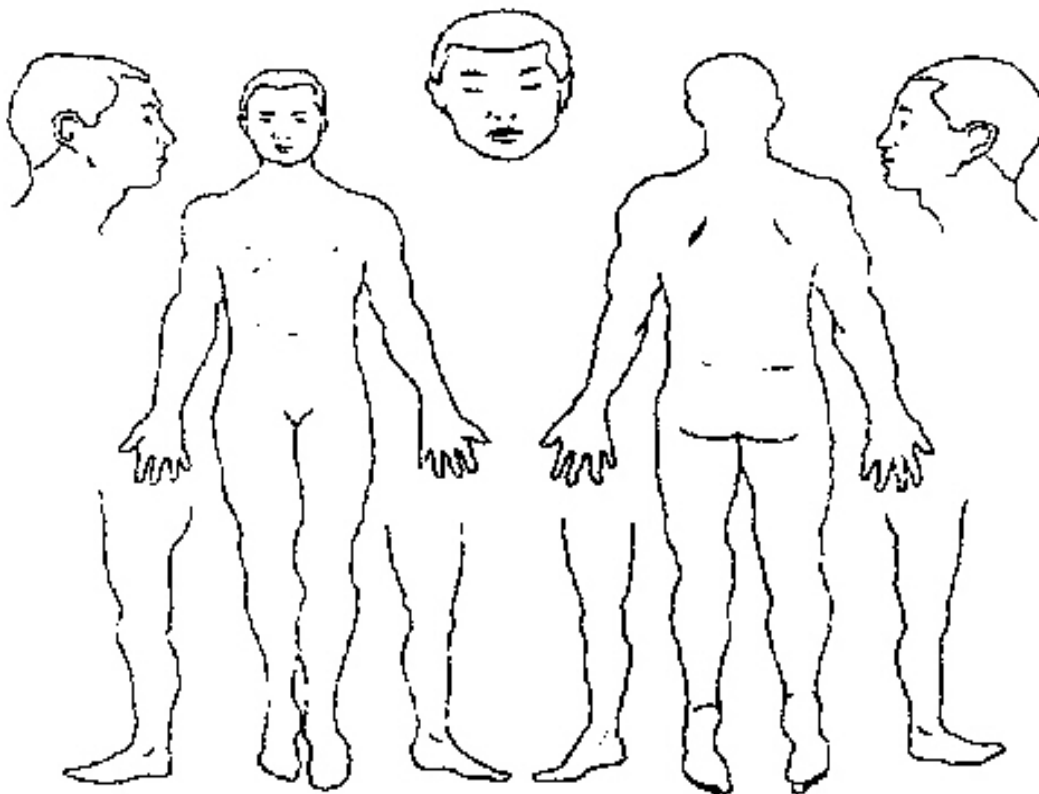
PLEASE INDICATE AREAS OF CONCERN OR PAIN BY CIRCLING THE DIAGRAM BELOW

Please indicate the intensity of your concern or pain by rating on a scale of 1-10:

1=barely notice to
10=unbearable.

Please indicate the nature of the pain or discomfort with the following:

Stabbing Pain = SP,
Tension & Tightness = T,
Numbness = N,
Dull Pain = DP,
Burning = B,
Ache = A



Patient's Name: _____

Today's Date: ____ / ____ / ____

Primary Care Physician: _____

Date of Last Physical: _____ Significant Results: _____

Specialists _____

- What are your treatment goals?
- Temporary relief of symptoms/pain control
 - Eliminate root or cause problem (if possible)
 - Maintenance care (periodic balancing tune-up to maintain wellness & health)
 - Other: _____

Are you willing to actively participate in your treatment and possibly modifying aspects of your diet and lifestyle that may be contributing to or aggravating your symptoms or condition? _____

PATIENT'S PAST MEDICAL HISTORY: *Please use the reverse of this sheet if needed for more detailed information.

Have you ever tested **positive** for: Hepatitis: Yes No Type: _____ OR HIV/AIDS: Yes No

Surgeries & Hospitalizations (type & dates) _____

Significant Illness (Please indicate if you have been diagnosed with any of the following; include dates): Cancer _____

High Blood Pressure _____ Rheumatic Fever _____ Sexually Transmitted Disease _____ Diabetes _____

Heart Disease _____ Seizures _____ Asthma _____ Stroke _____ Pacemaker _____

Thyroid Disease (hypo/hyper) _____ Other _____

Significant Physical Trauma (auto accidents, falls, dental work, etc.): _____

Significant Emotional Trauma (divorce, death, job change, etc.): _____

Occupational Stress (chemical, physical, psychological, etc.): _____

FAMILY MEDICAL HISTORY: (Please check all that apply)

High Blood Pressure Alcoholism Cancer (specify type below) Allergies (specify type below)

Heart Disease Seizures _____ _____

Arteriosclerosis Asthma _____ _____

Stroke Diabetes _____ _____

Other: _____

Please list significant prescription medication use in the past (please include antibiotic history): _____

Patient's Name: _____

Today's Date: ____ / ____ / ____

Please check any of the following symptoms that are relevant to your health history.

<p style="text-align: center;">General</p>	<p style="text-align: center;">Head, Eyes Ears Nose & Throat</p>	<p style="text-align: center;">Cardiovascular</p>	<p style="text-align: center;">Gastrointestinal</p>
<input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Sweat easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or Bruise easily <input type="checkbox"/> Peculiar taste in mouth <input type="checkbox"/> Strong thirst (cold or hot) <input type="checkbox"/> No desire to drink <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden drop in energy Time of day: _____ <input type="checkbox"/> Edema Location: _____ <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Weight change Gain / Loss; Amount _____	<input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches When: _____ Where: _____ <input type="checkbox"/> Facial Pain <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Poor vision Distance / Reading (circle) <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Floaters / spots in vision <input type="checkbox"/> Color blindness <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye strain <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye dryness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears High or Low pitch? <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth problems <input type="checkbox"/> Jaw clicks / popping <input type="checkbox"/> Concussions <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sores on lips / tongue	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest discomfort / pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Swelling of hands <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty breathing <p style="text-align: center;">Respiratory</p> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Difficulty breathing Lying down / Exertion <input type="checkbox"/> Phlegm Color? _____ <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <p style="text-align: center;">Genitourinary</p> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decrease flow <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Change in sex drive <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Wake to urinate in the night (# times) _____ Urine color: _____	<input type="checkbox"/> Bad breath <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Blood in stools bright red <input type="checkbox"/> Abdominal pain / cramps <input type="checkbox"/> Gas <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Hemorrhoids <p style="text-align: center;">Musculoskeletal</p> <input type="checkbox"/> Pain: <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Foot / Ankle <input type="checkbox"/> Hand / Wrist <input type="checkbox"/> Muscle pain / weakness <p style="text-align: center;">Neuropsychological</p> <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/ weakness <input type="checkbox"/> Vertigo <input type="checkbox"/> Bad temper <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety / easily stressed <input type="checkbox"/> Poor memory <input type="checkbox"/> Loss of balance <input type="checkbox"/> Violence potential <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Lack of coordination

Patient's Name: _____

Today's Date: ____/____/____

DIET AND LIFESTYLE

Please give a general description of the food you eat during a "typical" day.

Morning: _____

Afternoon: _____

Evening: _____

Before Bed: _____

Between Meals: _____

Are you now, or have you ever been on a restricted diet? Please describe diet and approximate dates: _____

Are you **MORE** than 20% **OVER** or Are you **MORE** than 20% **LESS** your ideal body weight? Yes / No

Have you been exposed to any known environmental toxins or hormones? Yes / No If yes, what? _____

Do you drink milk processed with antibiotics or growth hormones? Yes / No

Do you eat chicken or meat that has been treated with antibiotics or growth hormones? Yes / No

How often do you have bowel movement (s) per day? _____ or per week? _____

How much water do you drink per day? _____

How many caffeinated drinks per day? _____ Type of drinks: _____

Do you drink alcohol? Yes / No If yes, would you describe yourself as a daily social weekend or occas. drinker

How much alcohol do you drink per during a typical **week**? Hard Liquor (type & #) _____

Beer: __bottles/cans Wine (red white) __glass (es) __bottles

Are you presently taking steroids for any reason? Yes / No If yes, what are you taking and why? _____

Please describe your past or present recreational drug use (if any): _____

How many cigarettes or packs do you smoke a day? _____ For how many years? _____ Have you quit? (when) _____

Do you believe you have or have had any problem with substance abuse? Yes / No Describe: _____

Have you ever seen a mental health professional? Yes / No If yes, who did you see and for what purpose: _____

Do you exercise regularly? Yes / No Please describe: _____

Is there anything I have forgotten to ask which is important for me to know? _____

Do you have any questions for me? _____

Patient's Name: _____

Today's Date: ____ / ____ / ____

GYNECOLOGICAL HISTORY

of Pregnancies (dates): _____

of Births (dates): _____

of Miscarriages (dates): _____ # of Abortions (dates): _____

Menstrual History

Menopause (If yes, please answer menses questions for history information) Last menses start date: _____

Menopausal onset (age) & symptoms if applicable: _____

Age at first Menses: _____ Length of full cycle (days between menses i.e. 24, 28, 32, ...): _____

Length of menses/flow: _____ (# of heavy days _____ # of light days _____ # of days spotting _____)

Do you experience spotting before menses # of days ____ or after menses # of days _____ color _____

Heavy Flow (How often do you change tampon/pad in day)? _____ Blood color: _____

Light Flow (How often do you change tampon/pad in day)? _____ Blood color: _____

Irregular periods (variable, short, long, missed) please explain: _____

Painful periods, please describe: _____

Changes in body/psyche prior to menstruation _____

Clots large/small Scanty or missed periods Excessive irritability (before during or after menses)

Have you experienced any of the following?

Endometriosis Uterine Fibroids Ovarian cysts Polycystic Ovarian Disease

Post-coital bleeding Vaginal sores Vaginal dryness Vaginal Irritation

Abnormal Vaginal discharge: Color: _____ Consistency: _____ Odor: _____

Yeast Infections Normal stretchy egg white discharge at time of ovulation Urinary Tract Infections

Sexually transmitted diseases: _____

Date of last PAP: _____ Any abnormal PAPs in past? _____

Breast lumps (Do you examine yourself for breast lumps? Yes / No) Nipple discharge Breast tenderness

How would you rate your sexual energy? Low Medium High

How would you rate your overall level of sexual satisfaction? Low Medium High

Do you douche regularly? Yes / No If yes, with what? _____

Do you use vaginal lubricants? Yes / No If yes what kind (s)? _____

FEMALE FERTILITY HISTORY

Name of gynecologist &/or reproductive endocrinologist: _____

Do you practice birth control? Yes / No What type and for how long (i.e., birth control pill, IUD, condoms, etc.)? _____

Have you kept a Basal Body Temperature Chart? Yes / No (If yes, please bring copies to your initial visit.)

Have you ever been treated for infertility? Yes / No If yes, when, with whom, what was tried? _____

Have you taken medications to stimulate ovulation? Yes / No Please describe type, duration, & time frame: _____

Have your fallopian tubes been medically evaluated? Yes / No What were the results? _____

Have you had any gynecological operations or procedures (i.e., laparoscopy, abdominal surgery, pelvic / abdominal imagery such as ultrasound, etc.)? Yes / No If yes, please explain _____

Have you had blood work done to assess fertility & hormone factors? Yes / No If yes, please explain or bring labs: _____

If you have been trying to conceive, how long have you been actively trying? _____

Have you been given a medical diagnosis related to infertility or woman's reproductive health? Yes / No

If yes, please explain _____

Are you aware of any exposure to drugs or chemicals while your mother was pregnant with you? Yes / No

If yes, please describe _____

Any additional history or relevant information: _____

Patient's Name: _____

Today's Date: ____/____/____

MEN'S GENITOURINARY HEALTH HISTORY

Family Medical History of Prostate Disease, Cancer, Hypertrophy, explain _____

Have you experienced any of the following?

- Prostate Hypertrophy Failure to Ejaculate Premature Ejaculation
- Failure to maintain erection Inability to have erection Low Libido
- Dribbling Urination Weak Urine Stream Pressure or fullness in prostate area
- Abnormal Penile discharge: Color: _____ Consistency: _____ Odor: _____
- History of Kidney Infections, dates _____ History of Urinary Bladder Infections, dates _____
- History of trauma to the genital region, explain _____ Genital Sores
- Sexually transmitted diseases: _____
- Breast lumps (do you examine yourself for breast lumps? Yes/ No) Nipple discharge

How would you rate your sexual energy? Low Medium High

How would you rate your overall level of sexual satisfaction? Low Medium High

Have you experienced erectile dysfunction? Yes / No

Have you used medication (s) for erection? Yes / No. If yes, what type & time frame? _____

MEN'S FERTILITY HISTORY

Do you practice birth control? Yes / No What type and for how long (i.e., condoms, vasectomy, etc.)? _____

of Pregnancies with partner (s) & dates: _____

of Children / Birthdates: _____

Have you been given a medical diagnosis related to infertility? Yes / No. If yes explain. _____

Have you ever been treated for infertility? _____ If yes, when, with whom, what was tried? _____

Have you had a semen analysis? Yes / No. If yes, please explain or bring labs: _____

If you have been trying to conceive, how long have you been actively trying? _____

Do you wear tight fitting clothing that would confine genital region? Yes / No

Do you ride bikes long distance or mountain bike? Yes / No

Have you been exposed to any know environmental toxins or hormones? Yes / No If yes what? _____

Are you aware of any exposure to drugs or chemicals while your mother was pregnant with you? Yes / No.

If yes please describe _____

Are you presently taking steroids for any reason? Yes / No. If yes, what are taking and why? _____

Any additional history or relevant information: _____