Cary Acupuncture Clinic, Inc.

Patient Health History

Name: _____ **Date:** _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Address: _____ City/State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Person _____ Emergency Contact Phone: _____

Primary Care Physician _____

How did you hear about the Cary Acupuncture Clinic? _____

What do you expect from acupuncture/herbal medicine? _____

_____

Successful health care and preventative medicine are only possible when the practitioner 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. When and where did you last receive health care _____

For what reason? _____

2. What is the main reason for the appointment today? _____

_____

3. Please identify the health concerns that have brought you to the Cary Acupuncture Clinic in order of importance below:

List most important health concerns in order of significance	Prior diagnosis and treatment of the health concern
1	1
2	2
3	3
4	4

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

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? ☐ Y ☐ N If so, how far along are you? _____

7. Do you have any infectious diseases? ☐ Y ☐ N If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When taken? _____

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

☐ Scarlet Fever ☐ Diphtheria ☐ Rheumatic Fever ☐ Mumps ☐ Measles ☐ German Measles ☐ Chicken Pox

12. **Immunizations** (please check any that you have had): ☐ **H1N1**

☐ Polio ☐ Tetanus ☐ Pertussis ☐ Diphtheria ☐ Hib ☐ Hepatitis B ☐ Measles/Mumps/Rubella

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	

Please check any that you experience now and underline any that you have experienced in the past for questions 15 to 28:

15. **Emotional** ☐ Mood Swings ☐ Nervousness ☐ Mental Tension

16. **Energy and Immunity** ☐ Fatigue ☐ Slow Wound Healing ☐ Chronic Infections ☐ Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat**

☐ Impaired Vision ☐ Eye Pain/Strain ☐ Glaucoma ☐ Glasses/Contacts ☐ Tearing/Dryness
☐ Impaired Hearing ☐ Ear Ringing ☐ Earaches ☐ Hay Fever ☐ Sinus Problems
☐ Nose Bleeds ☐ Teeth Grinding ☐ TMJ/Jaw Problems
☐ Headaches/Migraines ☐ Frequent Sore Throats

18. **Respiratory**

☐ Pneumonia ☐ Frequent Common Colds ☐ Difficulty Breathing ☐ Emphysema
☐ Persistent Cough ☐ Pleurisy ☐ Asthma ☐ Tuberculosis ☐ Shortness of Breath

Other Respiratory Problems: _____

19. **Cardiovascular**

☐ Heart Disease ☐ Chest Pain ☐ Swelling of Ankle ☐ Stroke ☐ High Blood Pressure
☐ Palpitations/Fluttering ☐ Heart Murmurs ☐ Rheumatic Fever ☐ Varicose Veins

20. **Gastrointestinal**

☐ Epigastric Pain ☐ Nausea/Vomiting ☐ Passing Gas ☐ Ulcers ☐ Changes in Appetite
☐ Heartburn ☐ Hemorrhoids ☐ Belching ☐ Abdominal Pain ☐ Liver Disease
☐ Hepatitis B or C ☐ Gall Bladder Disease

21. **Genito-Urinary**

☐ Kidney Disease ☐ Painful Urination ☐ Frequent UTI ☐ Frequent Urination ☐ Heavy Flow
☐ Kidney Stones ☐ Impaired Urination ☐ Blood in Urine ☐ Frequent Urination at Night

22. **Female Reproductive/Breasts**

☐ Irregular Cycles ☐ Breast Lumps/Tenderness ☐ Nipple Discharge ☐ Heavy Flow
☐ Vaginal Discharge ☐ Premenstrual Problems ☐ Clotting ☐ Cramping
☐ Difficulty Conceiving ☐ Menopausal Symptoms ☐ Painful Periods ☐ Bleeding Between Cycles

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

24. **Male Reproductive** ☐ Sexual Difficulties ☐ Prostrate Problems ☐ Testicular Pain/Swelling ☐ Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

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

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

_____

26. **Neurologic**

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

27. **Endocrine**

☐ Hypothyroid ☐ Hyperthyroid ☐ Hypoglycemia ☐ Diabetes I or II ☐ Night Sweats ☐ Feeling Hot or Cold

28. **Other**

☐ High Cholesterol ☐ Anemia ☐ Cancer ☐ Rashes ☐ Eczema/Hives ☐ Cold Hands/Feet

Is there anything else we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____
b. How many glasses of water do you drink per day _____
c. Exercise practice _____
d. Spiritual practice _____
e. How many hours per night do you sleep? _____ Do you wake rested? Y N
f. Do you enjoy work? Y/N Occupation: _____ Hours/Week: _____
g. Nicotine/Alcohol/Caffeine Use: _____
h. Have you experienced any major traumas? Y N Explain: _____

_____

i. Interests and hobbies: _____