

Please complete this health questionnaire carefully. All information provided is kept completely confidential. If you have any questions, please direct them to Sarah Contreras, LAc, LMP at 425/303-3363. Thank you.

Health History Questionnaire

Date _____ / _____ / _____

Name		Home Phone	Cell Phone
Address		Street	City/State/Zip
Date of Birth	Age	Occupation	
Height	Weight	Primary Care Physician	Your email
Emergency Contact		Emergency Contact Phone	Relationship

Current/Past Medical History (Include dates if possible)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDs/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | _____ |
| | <input type="checkbox"/> Migraines | | |

Surgeries/ Significant Trauma (Include date) _____

Do you have any scars? Where? Are they painful? _____

Dental Work _____

- Family Medical History**
- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Depression | | _____ |

Please list the medications taken in the last year. (Include medications, vitamins, herbs, etc.)

Do you exercise? (What type and how often) _____

Do you smoke cigarettes? (Yes / No) If yes, how many per day _____

Do you drink alcohol? (Yes / No) If yes, how much per week _____

How much coffee, tea or cola do you drink per day? _____

Are you currently pregnant? (Yes / No)

Are you currently under stress? (Yes / No)

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE LAST 3 YEARS

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Peculiar tastes or smells <input type="checkbox"/> Fatigue <input type="checkbox"/> Edema - Where? _____ <input type="checkbox"/> Poor sleep <input type="checkbox"/> Change in appetite <input type="checkbox"/> Weight gain or loss <p>Skin and Hair</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Hives <input type="checkbox"/> Acne <input type="checkbox"/> Recent moles <input type="checkbox"/> Hair loss <input type="checkbox"/> Other _____ <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Production of phlegm <input type="checkbox"/> Pneumonia or bronchitis <input type="checkbox"/> Other _____ <hr/> <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Acid regurgitation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black stools <input type="checkbox"/> Mucous in stools <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Gas <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Hemorrhoids/anal fissures <input type="checkbox"/> Other _____ <hr/> <p>Genito-Urinary</p> <ul style="list-style-type: none"> <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 in flow <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney stones 	<ul style="list-style-type: none"> <input type="checkbox"/> Impotency <input type="checkbox"/> Change of sexual drive <input type="checkbox"/> Genital itching <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Waking to urinate at night? <input type="checkbox"/> Other _____ <p>Head, Eyes, Ears, Nose, Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <input type="checkbox"/> Concussions <input type="checkbox"/> Facial Pain <input type="checkbox"/> Sinus problems <input type="checkbox"/> Excessive phlegm <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Swollen glands <input type="checkbox"/> Sores on lips or tongue <input type="checkbox"/> Gum/teeth problems <input type="checkbox"/> Glasses <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye dryness or excessive tearing <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing aid <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Other _____ <p>Pregnancy and Gynecology</p> <p>Number of pregnancies _____</p> <p>Number of births _____</p> <p>Number of miscarriages _____</p> <p>Number of abortions _____</p> <p>Age at first menses _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal sores <input type="checkbox"/> Date of last Pap _____ <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Other _____ <p>Cardiovascular</p> <ul style="list-style-type: none"> <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 	<ul style="list-style-type: none"> <input type="checkbox"/> Other cardiovascular problems <hr/> <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Back pain <input type="checkbox"/> Low back pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Generalized muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Other _____ <hr/> <p>Neuropsychological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Loss of balance or poor balance <input type="checkbox"/> Tremors <input type="checkbox"/> Tics <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Concussion <input type="checkbox"/> Bad temper <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> Frustration <input type="checkbox"/> Sadness <input type="checkbox"/> Anxiety <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Poor memory <input type="checkbox"/> Substance abuse <input type="checkbox"/> Abuse survivor <p>Have you ever seen a psychologist or psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other neurological or psychological problems</p> <p>_____</p> <hr/> <p>***ANY HEALTH ISSUES NOT MENTIONED ON THIS FORM:</p>
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