

Health History Questionnaire

Please help me to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential, unless you sign an authorization form for your records to be released.

Name (Last, First)	Date of Birth: Sex:	Today's Date:
Address:	City: State:	Zip:
Primary Phone:	Name of Emergency Contact:	Emergency Contact Phone:
Primary Physician:	Date of last physical:	How did you hear about Full Bloom?
Email:	How do you prefer to be contacted? Phone <input type="checkbox"/> Email <input type="checkbox"/>	I

Have you ever been treated by acupuncture before? Yes No

What health concern(s) do you want to address?
How long ago did this/these health concern(s) begin?
Is there a known cause/instigating factor for your health concern?
Have you seen a doctor about this/these concern(s)? If so, has your doctor given you a diagnosis?
What treatments have you tried?
Is there a chance that you may be pregnant? (Females)
List medications you are currently taking, including herbs and supplements:
List any significant traumas and approximate date(s) (auto accidents, injuries, emotional traumas, etc.):
List any surgeries you have had (indicate date):
Do you have a regular exercise program? (Describe)
Are you on a restricted diet? (If so, what type)

Medical History

Please indicate if you have a history of the following medical conditions/symptoms:

GENERAL

- Bleeding / Bruising
- Cancer
- Diabetes
- Hepatitis
- Seizures
- Insomnia
- Thyroid Disorder
- Chills
- Fever
- Sweats easily
- Night Sweats
- Fatigue
- Edema
- Poor appetite
- Weight gain
- Weight loss

SKIN AND HAIR

- Rashes
- Itching
- Ulcerations
- Eczema
- Hives
- Acne
- Hair loss
- Dandruff
- Other: _____

HEAD, EYES, EARS, NOSE, AND THROAT

- Dizziness
- Headaches
- Poor vision
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tearing
- Poor hearing
- Ringing in ears
- Ear ache
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Grinding teeth
- Teeth problems
- TMJ
- Recurrent sore throats
- Mouth or tongue sores
- Other: _____

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Heart disease
- Chest pain
- Heart palpitations
- Blood clots
- Stroke
- Fainting
- Difficulty breathing
- Poor circulation
- Other: _____

RESPIRATORY

- Cough
- Asthma / wheezing
- Production of phlegm
- Coughing blood
- Pneumonia
- Bronchitis
- Other: _____

GASTROINTESTINAL

- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Bad breath
- Diarrhea
- Constipation
- Blood in stools
- Abdominal pain or cramping
- Gas
- Rectal pain
- Hemorrhoids
- Other: _____

GENITO-URINARY

- Pain on urination
- Urgency to urinate
- Frequent urination
- Blood in urine
- Incontinence
- Dribbling
- Kidney stones
- Impotency
- Change of sexual drive
- Sexually transmitted disease
- Other: _____

MUSCULOSKELETAL

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain

- Hand / Wrist pain
- Hip pain
- Knee pain
- Foot / Ankle pain
- Muscle pain
- Muscle weakness
- Other: _____

NEUROPSYCHOLOGICAL

- Seizures
- Numbness
- Tremors
- Lack of coordination
- Depression
- Anxiety
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Substance abuse
- Other: _____

Have you ever been treated for emotional problems?

- Yes No

Have you ever considered or attempted suicide?

- Yes No

PREGNANCY AND GYNECOLOGY

- Number of pregnancies: _____
- Number of births: _____
- Miscarriages
- Abortions
- Age at first menses _____
- Length of cycle _____
- Heavy periods
- Light periods
- Painful periods
- Irregular periods
- Clotting
- Changes in body / psyche prior to menses

Menopause:

Age _____

- Vaginal discharge
- Breast lumps
- Nipple discharge

Do you practice birth control?

- Yes No

If so, what type: _____