MEGAN GODFREY
TRADITIONAL FIVE ELEMENT ACUPUNCTURE

HEALTH HISTORY QUESTIONNAIRE

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Your answers will be held *completely* confidential. Please bring this with you to your first appointment. Thank you.

_____Today's date

NAME:
PHONE (cell): (home): (work):
EMAIL:
STREET: CITY/ST: ZIP:
DATE OF BIRTH: AGE: HT: WT:
PLACE OF BIRTH: MARITAL STATUS:
CHILDREN (names and ages):
OCCUPATION:
FAMILY PHYSICIAN (name and phone):
MAIN CONCERN (When did this begin? To what extent does it interfere with your daily activities? Have you been given a diagnosis? What treatments have you tried?):

MEDICAL HISTORY (please include dates):

SIGNIFICANT ILLNESSES (circle): Cancer Diabetes High blood pressure Heart disease Rheumatic fever Thyroid disease Seizures Infectious diseases (suspected or diagnosed HIV, TB, Hepatitis) Other:
SURGERIES (please include dates):

SIGNIFICANT TRAUMA (auto accidents, falls, etc. with dates):

ALLERGIES:
FAMILY MEDICAL HISTORY (circle): Cancer Diabetes High blood pressure
Heart disease Stroke Seizures Asthma Allergies Other:

MEDICINES (taken within last two months; vitamins, drugs, herbs):

OCCUPATIONAL STRESS (chemical, physical, psychological, etc.):

EXERCISE:

DIET: Please describe your average daily diet including drink, snacks, and sweets:
Morning: Noon: Evening:

How many 12 oz. glasses of water do you drink a day?
Have you ever been on a restricted diet? (when and what kind)

How many packs of cigarettes do you smoke daily?
How much coffee, tea, or cola do you drink per week?
How much alcohol do you drink per week?
Please describe any recreational drug use:

Please check if you have had any of the following in the last three months.

GENERAL

poor appetite	poor sleeping	fatigue
fevers	chills	night sweats
tremors	cravings	sweat easily
localized weakness	poor balance	change in appetite
bruising or bleeding	weight gain or loss	strong thirst
other:		

SKIN AND HAIR

rashes	ulcerations	hives
itching	eczema	pimples
dandruff	loss of hair	recent moles
other:		

HEAD, EYES, EARS, NOSE, AND THROAT

dizziness	migraines	eye strain or pain
poor vision (glasses?)	night blindness	cataracts
earaches	ringing in ears	poor hearing
nose bleeds	sinus problems	jaw clicks
recurrent sore throats	teeth problems	sores on lip or tongue
headaches (where and when):	other:	

CARDIOVASCULAR

high blood pressure	low blood pressure	chest pain
irregular heartbeat	fainting	cold hands or feet
swelling of hands or feet	difficulty breathing	blood clots
other:		

RESPIRATORY

cough	coughing blood	asthma
bronchitis	pneumonia	pain with deep breath
other:		

GASTROINTESTINAL

nausea	vomiting	indigestion
constipation	diarrhea	gas
belching	black stools	blood in stools
rectal pain	hemorrhoids	cramps
bad breath	chronic laxative use	other:

GENITO-URINARY

pain on urination	frequent urination	blood in urine
urgency to urinate	unable to hold urine	kidney stones
decrease in flow	impotency	sores on genitals
wake to urinate (how often)	other:	

REPRODUCTIVE AND GYNECOLOGICAL

Please provide the number or date on the line where appropriate.

pregnancies____	births____	premature births____
miscarriages____	abortions____	age at first menses____
days between menses____	duration menses (#days)___	last menses (date)_____
very heavy or light menses	clots	cramps or pain
PMS	vaginal discharge	vaginal sores
infertility	breast lumps	last PAP (date)_____
age at menopause____	Do (/did) you practice birth control? (what type and how long)	
other:		

MUSCULOSKELETAL

neck pain	muscle pains	knee pain
back pain	muscle weakness	foot/ankle pain
hand/wrist pain	shoulder pain	hip pain
other:		

NEUROPSYCHOLOGICAL

seizures	loss of balance	areas of numbness
lack of coordination	poor memory	concussion
depression	anxiety	temper
easily susceptible to stress	emotional problems	suicidal thoughts
other:		

PLEASE MENTION ANY OTHER CONCERNS: