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Acupuncture Wellness & Fertility Clinic

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847.957.7877

New Patient Health History Questionnaire
(Confidential Information)

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but from a Chinese medical perspective they may play a major role in diagnosis and treatment.

All information is strictly confidential.

GENERAL PATIENT INFORMATION

Date: _________________ Name: ____

Address: ________________________________ City, State, Zip: ____________________________

Home Phone: _________________ Work Phone: __________________ Cell Phone: ______________

Age: ______ Date of Birth: ___________________ Email: _____________________________________

Legal Guardian: (if under 18 years of age) ____

Emergency Contact: (name and phone number) ____

Gender: ___ M ___ F Height:____ ' ___" Weight:____lbs

Occupation: ________________________________ Employer: _________________________________

How did you hear about us? ____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

(If pain related, please include severity from 1-10 (mild-extreme) & percentage of time you experience pain in a 24 hour period next to complaint)

1. ____ 2. ____

3. ____ 4. ____

5. ____ 6. ____

Which activities are difficult to perform if your issue is pain related?

Sitting *Bending* *Standing* *Lying Down* *Walking* *Lifting* *other*________________

Does your pain interfere with your: *Sleeping* *Dressing* *Tying Shoes* *Work performance* *Bathing* *Preparing Food* *Eating* *Taking Medicine* *Walking* *Exercising*

PATIENT MEDICAL HISTORY

How was your childhood health? ____

Hospital visits/stays: ____

Recent Tests: (please indicate test results and date below)

•Physical •Cholesterol •Prostate •Blood (which?) •HIV/STD •Pap Smear •Mammography •Other

Test results and date: ____

Check any that you have had in the past:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Jaundice
- ☐ Syphilis
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Paralysis
- ☐ Other Lung Illness
- ☐ Allergies
- ☐ CVA (stroke)
- ☐ Pneumonia
- ☐ Gonorrhea
- ☐ Measles
- ☐ HIV
- ☐ High Fever
- ☐ Cancer
- ☐ Other Liver Illness
- ☐ Glaucoma
- ☐ Vein Condition
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hepatitis
- ☐ Migraines
- ☐ Other Heart Illness
- ☐ Rheumatic Fever
- ☐ Thyroid Disorder
- ☐ Emphysema
- ☐ Bleeding Tendency
- ☐ Nervous Disorder
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ High Blood Pressure
- ☐ Other Kidney Illness

☐ Other ____

Immunizations: ____

Surgeries: ____

PATIENT PROFILE

Please clearly mark any areas of pain and any scares (please indicate which of the areas are scars)

Is the pain:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Moving
- ☐ Fixed
- ☐ Other: ____________________

Do the following improve the pain?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other: ____________________

Do the following worsen the pain?

- ☐ Pressure
- ☐ Heat
- ☐ Cold
- ☐ Other: ____________________