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HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

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

Date of Birth: _____ **Gender M F** **Age:** _____ **Weight:** _____ **Height:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Best Phone: _____ **Other Phone (please specify):** _____

E-Mail: _____

Marital Status: Single Married Partner/Live-In In a Relationship Separated Divorced Widower

Physician: _____ **Phone:** _____

In Emergency Notify: _____ **Phone:** _____

How did you hear about Blue Heron Acupuncture & Apothecary? _____

Referred by: _____ **Your Occupation:**_____

How would you like to be reminded of your next appointment? phone call text email

If text, who is your mobile provider? _____

What is your MAIN CONCERN?_____

Symptoms_____

Western Diagnosis, if any:_____

When did you first notice symptoms?_____

What makes your condition better?_____

What makes your condition worse?_____

GENERAL HISTORY

Significant Trauma (physical or emotional; please list age or date)

Your
Birth History (prolonged labor, forceps delivery, C-section delivery, complications, postpartum depression in mother, etc.)

Childhood Illness: Mumps Measles Rubella Diphtheria Chicken Pox Rheumatic Fever Polio
Other:

Do you have any infectious diseases? ☐ Yes ☐ No **If yes, please identify:** _____

Hospitalizations/Surgeries/Accidents (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

_____

Vitamins/Supplements/Herbs (with dosages, if you know them)

_____

Exercise
Days per week Length of workout Type of Activity

Diet
Meals per day Snacks Cravings Are you happy with your weight?

Beverages (list # of cups/cans per day)
☐ Coffee ☐ Tea ☐ Soda ☐ Alcohol (drinks per week)

Tobacco/Drugs
☐ Tobacco Type: Amount: # of years:

☐ Recreational Drugs Type: Frequency:

Stress level Low Med High

Do you have adequate physical and emotional support at home to meet the challenges of your present condition? Yes No

Personal History

Please check any conditions or symptoms you have now**.**

☐ **Stroke**	☐ **Heart Disease**	☐ **High/Low Blood Pressure**	☐ **High Cholesterol**
☐ **Cancer**	☐ **Diabetes**	☐ **Hyper/Hypothyroidism**	☐ **Food Allergies/Intolerance**
☐ **Gastritis/Pancreatitis**	☐ **Irritable Bowel Syndrome**	☐ **Crohn's Disease**	☐ **Diverticulitis**
☐ **Hepatitis**	☐ **HIV/AIDS**	☐ **Kidney Disease**	☐ **Seizures**
☐ **Chronic Fatigue**	☐ **Anemia**	☐ **Raynaud's Disease**	☐ **Lyme Disease**
☐ **Chronic Pain Condition**	☐ **Asthma**	☐ **Respiratory Allergies**	☐ **Emphysema**
☐ **Tuberculosis**	☐ **Lupus**	☐ **Rheumatoid Arthritis**	☐ **Osteoarthritis**
☐ **Infertility**	☐ **Impotence**	☐ **Alcoholism/Substance Abuse**	☐ **Other: _____**

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

☐ Diabetes ___	☐ Seizures ___	☐ Heart Disease ___	☐ Stroke ___
☐ High Blood Pressure ___	☐ Allergies ___	☐ Cancer ___	☐ Asthma ___
☐ Mental Illness ___	☐ Emotional Disorders ___	☐ Kidney Disease___	☐ Substance Abuse___

☐ Other_____

Please check any that you are experiencing:

General

☐ Fever	☐ Poor Sleeping	☐ Fatigue	☐ Peculiar tastes/smells
☐ Chills	☐ Night Sweats	☐ Sweats Easily	☐ Tremors
☐ Frequent colds or flus	☐ Localized Weakness	☐ Change in appetite	☐ Dizziness
☐ Bleed/Bruise easily	☐ Weight loss/gain	☐ Strong thirst	☐ Sudden energy drop

Skin and Hair

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Hair Loss	☐ Recent moles
☐ Skin discoloration	☐ Acne	☐ Change in skin/hair texture	☐ Face flushing
☐ Dermatitis	☐ Warts	☐ Fungal Infection	☐ Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

☐ Headaches	☐ Migraines	☐ Glasses	☐ Tearing/Dry Eyes
☐ Eye Strain	☐ Eye pain	☐ Poor vision	☐ Night Blindness
☐ Spots in front of eyes	☐ Glaucoma	☐ Cataracts	☐ Blurred vision
☐ Earaches	☐ Ringing in ears	☐ Poor hearing	☐ Sinus problems
☐ Nose bleeds	☐ Recurrent sore throats/colds	☐ Grinding teeth	☐ Facial pain
☐ Sores on lips/tongue	☐ Dental/gum problems	☐ TMJ/Jaw clicks/locks	☐ Difficulty swallowing

Cardiovascular

☐ Chest pain or pressure	☐ Irregular heart beat	☐ Palpitations at rest	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands/feet	☐ Blood clots	☐ Phlebitis
☐ Shortness of breath	☐ Varicose/spider veins	☐ Pressure in chest	☐ High blood pressure
☐ Low blood pressure	☐ Spontaneous sweating	☐ Rheumatic fever	☐ Heart murmur

Respiratory

☐ Cough/Wheezing	☐ Coughing blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Pain with deep inhalation	☐ Tight sensation in chest	☐ Difficult inhale/exhale
☐ Difficulty breathing when lying down		☐ Production of phlegm… what color? _____	

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Gas	☐ Belching	☐ Black stools	☐ Blood in stool
☐ Indigestion	☐ Bad breath	☐ Rectal pain	☐ Hemorrhoids
☐ Bloating/Edema	☐ Chronic laxative use	☐ Parasites	☐ Abdominal pain/cramps
☐ Changes in appetite	☐ Acid reflux/GERD	☐ Hernia	☐ Poor appetite
☐ Excessive appetite	☐ Significant thirst	☐ Ulcer	☐ Gallstones

Musculoskeletal

☐ Neck pain	☐ Shoulder pain	☐ Hand/wrist pain	☐ Carpal Tunnel
☐ Knee pain	☐ Sprains/Strains	☐ Sciatica	☐ Foot/ankle pain
☐ Hip pain	☐ Muscle pain	☐ Muscle weakness	☐ Muscle cramps
☐ Tendonitis	☐ Bursitis	☐ Rotator Cuff	☐ Joint Pain

☐ Back pain Low___ Middle___ Upper___ ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neurological

☐ Seizures	☐ Loss of balance	☐ Vertigo/Dizziness	☐ Areas of numbness
☐ Lack of coordination	☐ Poor memory	☐ Concussion	☐ ADD/ADHD

Emotional

☐ Mood Swings	☐ Irritability	☐ Nervousness	☐ Constant Anxiety
☐ Panic Attacks	☐ Situational Anxiety	☐ Social Anxiety	☐ Depression
☐ Irrational Fears	☐ Lack of Motivation	☐ Constant Worrying	☐ Seasonal Affective Disorder
☐ Obsessive Behavior	☐ Anger	☐ Manic Depression	☐ Sadness/Grief

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Have you ever been treated for substance abuse? ☐ Yes ☐ No

Genito-Urinary (Men)

Are you and your partner trying to conceive? ☐ Yes ☐ No

How long have you and your partner been trying to conceive? _____

Are you currently undergoing assisted reproductive fertility treatments (IUI, IVF, ICSI, superovulation, etc.)? ☐ Yes ☐ No

If yes, at what clinic? _____

How would you define your sexual energy? ☐ Below Normal ☐ Normal ☐ Above Normal

Have you had a recent physical exam? ☐ Yes ☐ No **Date of exam?** _____

Have you ever been diagnosed with or experienced:

☐ Undescended Testicle	☐ Varicocele	☐ Erectile Dysfunction	☐ Difficulty Ejaculating
☐ Premature Ejaculation	☐ Nocturnal Emission	☐ Penile Discharge	☐ Sores on Genitals
☐ Genital Itch	☐ Small or Soft Testes	☐ Prostate Conditions	☐ Incontinence
☐ Decrease in urine flow	☐ Stop and start urine flow	☐ Blood in Urine	☐ Burning or Painful Urination
☐ Urinary Tract Infection	☐ Kidney Stones	☐ STDs If yes, please list _____	

Have you had any urological surgeries? ☐ Yes ☐ No **If yes, specify:** _____
Have you experienced a high fever in the last six (6) months? ☐ Yes ☐ No
Have you had exposure to any known environmental toxins or hormones? ☐ Yes ☐ No

Have you ever taken testosterone supplements or drugs? ☐ Yes ☐ No
Have you recently had your testosterone levels checked? ☐ Yes ☐ No
Have you been checked for blockage of your reproductive tract? ☐ Yes ☐ No

Have you had a fertility work up? ☐ Yes ☐ No
If yes, what was your sperm count? ☐ Below Normal ☐ Normal ☐ Number: _____
What was the sperm mobility: ☐ Below Normal ☐ Normal ☐ Notes: _____
What was the sperm morphology? ☐ Abnormal ☐ Normal ☐ Notes: _____

Comments: Please inform me of any other problems or goals for your health that you would like to discuss.

_____

_____

_____