

Whole Health Acupuncture and Herbal Medicine

60 Forest Falls Drive
Yarmouth, ME 04096

Health History Form

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

Name: _____	Date: _____	
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	
Mobile Phone: _____	E-mail: _____	
Date of Birth: _____	Age: _____	Marital Status: _____
Occupation: _____	Referred by: _____	
Physician: _____	Phone: _____	
Physician's Address _____		
In Emergency Notify _____	Phone: _____	

Main Complaint (symptoms, diagnosis, duration, etc.) _____

Significant Trauma (physical, emotional) & **Surgeries** (please include date of procedure) _____

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

Medications/Vitamins/Supplements/Herbs *please attach an additional page if necessary* _____

Birth History (prolonged labor, forceps delivery, complications, etc.) _____

Exercise: Days per week _____ Length of workout _____ Type of Activity _____

Typical Diet: Breakfast _____ Lunch _____ Dinner _____

Snacks _____ Caffeinated Drinks (what/how many) _____ Alcohol per week _____

Personal History Please check any conditions or symptoms you have or have had.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> IBS/Diverticulitis |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

Family Medical History Please check any condition that applies to your immediate family.

- | | | |
|--|--|---------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
-

Please Check if you have had any of these items listed below in the last 3 months.

General Symptoms

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Dental/gum problems | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/ smells | <input type="checkbox"/> tremors |
| <input type="checkbox"/> Muscle Weakness/Fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Bleed/BruiSe easily |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infections | |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Headaches | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Jaw Clicks/locks |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Earaches | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Recurrent sore throat/Cold | <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Nose bleeds | |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sinus Problems | |

Cardiovascular

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting | |

Respiratory

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficult breathing laying down |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficult inhale | <input type="checkbox"/> Production of phlegm |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult exhale | |

Gastrointestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Mucous in stool |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools | <input type="checkbox"/> Abdominal pain/Cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux//GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty urine flow | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Copious urine flow | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Burning urination | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination - How often? _____ What times? _____ | | | |

Gynecological/Reproductive

- | | | |
|--|--|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ |
| <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ | <input type="checkbox"/> Number of abortions _____ |
| <input type="checkbox"/> Do you practice birth Control? _____ What type? _____ For how long? _____ | | |

Musculoskeletal

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Rotator cuff |

Neuropsychological

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Depression | <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Seasonal Affective Disorder | <input type="checkbox"/> Seeing a therapist | <input type="checkbox"/> Poor memory |
| | | | <input type="checkbox"/> Areas of numbness |

On the back of this form please inform us of any other problems you would like to discuss.