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.

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

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

☐Diabetes	☐Seizures	☐Cancer
☐High blood pressure	☐Allergies	☐Stroke
☐Other__________________________	☐Heart Disease	☐Asthma

____

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

General Symptoms

☐Poor Appetite	☐Poor Sleep	☐Fatigue	☐Fever
☐Heavy appetite	☐Dental/gum problems	☐Sweat Easily	☐Night Sweats
☐Strongly like cold drinks	☐Bodily heaviness	☐Poor Balance	☐Cold hands or feet
☐Strongly like hot drinks	☐Weight loss/gain	☐Peculiar tastes/ smells	☐tremors
☐Muscle Weakness/Fatigue	☐Sudden energy drop	☐Change in appetite	☐ Bleed/Bruise easily

Skin and Hair

☐Rashes	☐Ulcerations	☐Hives/Allergic Dermatitis	☐Itching
☐Eczema/Psoriasis	☐Dandruff	☐Loss of hair	☐Recent moles
☐Skin discoloration	☐Acne	☐Change in texture	☐Face flushing
☐Dermatitis	☐Warts	☐Fungal Infections	

Head, Eyes, Ears, Nose and Throat

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

Cardiovascular

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

Respiratory

☐Cough/Wheezing ☐Pain with deep inhalation ☐Bronchitis ☐Difficult breathing laying down

☐Pneumonia ☐Asthma ☐Difficult inhale ☐Production of phlegm

☐Coughing blood ☐Tight sensation in chest ☐Difficult exhale

Gastrointestinal

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

☐Gas ☐Belching ☐Black stools ☐Blood in stool

☐Indigestion ☐Bad breath ☐Rectal Pain ☐Mucous in stool

☐Bloating/Edema ☐Chronic laxative use ☐Loose stools ☐Abdominal pain/Cramps

☐Changes in appetite ☐Acid reflux//GERD ☐Hernia ☐ Hemorrhoids

☐Excessive appetite ☐Significant thirst ☐IBS/Crohn's Disease

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Impotence

☐Unable to hold urine ☐Kidney stones ☐Scanty urine flow ☐Nocturnal emission

☐Urgent urination ☐Sores on genitals ☐Copious urine flow ☐Premature ejaculation

☐Burning urination ☐Decreased libido ☐Prostatitis ☐Dribbling after urination

☐Urinary tract infection ☐Pain in testicles ☐Herpes ☐Infections

☐Night urination - How often?________ What times?________

Gynecological/Reproductive

☐Difficult/Painful intercourse ☐Endometriosis ☐Date of last menses__________

☐Vaginal Dryness ☐Uterine Fibroids ☐Date of last PAP/Pelvic__________

☐Vaginal sores ☐Fibrocystic breast tissue ☐Number of pregnancies__________

☐Vaginal Discharge ☐Polycystic Ovarian Syndrome ☐Number of ectopic pregnancies_____

☐Infertility ☐PMS ☐Number of live births__________

☐Irregular Menstruation ☐Painful menstruation ☐Number of miscarriages__________

☐Ovarian cysts ☐Age of first menses__________ ☐Number of abortions_________

☐Do you practice birth Control?__________ What type?__________ For how long?__________

Musculoskeletal

☐Neck pain ☐Knee pain ☐Limited range of motion ☐Bursitis

☐Shoulder pain ☐Hand/wrist pain ☐Sprains/Strains ☐Carpal tunnel

☐Hip pain ☐Foot/ankle pain ☐Muscle pain ☐Tendonitis

☐Back pain ☐Muscle weakness ☐Sciatica ☐Rotator cuff

Neuropsychological

☐Seizures ☐Nervousness ☐Bad temper/irritable ☐ADD/ADHD

☐Lack of coordination ☐Depression ☐Considered/attempted suicide ☐Easily stressed

☐Anxiety/panic attacks ☐Seasonal Affective Disorder ☐Seeing a therapist ☐ Poor memory

☐Areas of numbness

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