

Today's Date: \_\_\_\_\_

# Acumedicine Associates, P.C.

8700 Georgia Avenue, Silver Spring, Maryland 20910, 301-562-0305

## Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All answers are confidential. Please ask if you have any questions. If there is anything you wish to bring to our attention, please note it in the comments section. Thank you.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you tried acupuncture or herbal medicine before? \_\_\_\_\_

**Main problem(s)** you would like to address: \_\_\_\_\_

When did you first notice these symptoms: \_\_\_\_\_

What extent does this problem affect your daily activities (work, sleep, eating exercise) \_\_\_\_\_

Has your physician given you a diagnosis? \_\_\_\_\_ What is the diagnosis: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

What kind of treatment, therapy, or medications have you tried for this problem? \_\_\_\_\_

Additional Information \_\_\_\_\_

### Past Medical History

_____ Asthma	_____ HIV/AIDS	_____ Pacemaker	_____ Port
_____ Cancer	_____ Blood Clots	_____ Diabetes	_____ Other
_____ Hypoglycemia	_____ High Blood Pressure	_____ High Cholesterol	
_____ Rheumatic fever	_____ Low Blood Pressure	_____ Thyroid Disease	
_____ Heart Disease	_____ Phlebitis	_____ Seizures	
_____ Hepatitis	_____ GI tumors or polyps	_____ Implant	

Accidents or significant trauma \_\_\_\_\_

Surgeries \_\_\_\_\_

List location of all scars (surgical and injury) \_\_\_\_\_

Allergies \_\_\_\_\_

Vaccination History: Any reactions that you remember or any unusual vaccinations? \_\_\_\_\_

List medications you have taken in the past six months. Include vitamins, herbs, drugs etc.(even if you take them only occasionally) \_\_\_\_\_

**Family Medical History** List family member as: **M**other, **F**ather, **S**ister, **B**rother, **S**on, **D**aughter. Add **P**aternal or **M**aternal prefix for **C**ousin, **A**unt, **U**ncle, **G**randparents. List any pertinent information you would like to include.

_____ Alcoholism _____	_____ Diabetes _____
_____ Allergies _____	_____ Heart Disease _____
_____ Asthma _____	_____ Seizures _____
_____ Cancer _____	_____ Stroke _____
_____ Other _____	

**Number of Children** – Please indicate by gender and age: \_\_\_\_\_

**Occupational Stress Factors**---Please indicate physical, psychological, chemical stressors: \_\_\_\_\_

**Lifestyle**---Have you undergone a major life change in the past year (change in job, marital status, birth, death, move, etc)? Please briefly describe the change \_\_\_\_\_

Describe your general overall emotional status \_\_\_\_\_

Describe your primary social relationships/support network \_\_\_\_\_

Do you follow a regular exercise program?\_\_\_\_\_ Please describe \_\_\_\_\_

How many sit-down meals do you have in a day?\_\_\_\_\_ Where?\_\_\_\_\_

When is your first meal of the day?\_\_\_\_\_ What is it usually?\_\_\_\_\_

When and what is your last meal of the day? \_\_\_\_\_

What do you snack on during the day?\_\_\_\_\_ When do you snack?\_\_\_\_\_

What veggies do you like?\_\_\_\_\_ What veggies do you dislike? \_\_\_\_\_

What animal protein do you prefer or eat most frequently? \_\_\_\_\_

What foods do you think you need or should be eating? \_\_\_\_\_

Cravings:\_\_\_\_\_ Prefer snacks that are:  Sweet  Salty  Crunchy

Please indicate if you use any of the following; include frequency and amount:

Alcohol \_\_\_\_\_ Cigarettes/Tobacco products \_\_\_\_\_

Caffeine \_\_\_\_\_ Diet soft drinks \_\_\_\_\_

Do you generally feel warmer or colder than others?\_\_\_\_\_ What season(s) do you prefer? \_\_\_\_\_

Are you frequently thirsty?\_\_\_\_\_ How much water do you drink in a day? \_\_\_\_\_

What temperature do you prefer your drinks? \_\_\_\_\_

**Sleep**---How many hours of sleep do you require?\_\_\_\_\_ Are you refreshed upon awakening? \_\_\_\_\_

Do you experience insomnia?\_\_\_\_\_ Describe the frequency and nature \_\_\_\_\_

**General**---Do you experience any of the following? Indicate any **C**urrent problem or symptom with a **C**; use a **P** for items that affected you in the **P**ast.

_____ Bleeding or bruising easily	_____ Frequent sighing	_____ Poor balance or lack of coordination
_____ Recent changes in weight	_____ Tremors	_____ Fatigue or exhaustion
_____ Energetic through evening up to Midnight but hate to wake up early in A.M.		_____ Difficulty concentrating on a task

Do you have any areas of numbness or tingling? \_\_\_\_\_

**Skin and Hair**

Dry hair                       Itching                       Acne  
 Hair loss                       Psoriasis                       Fungal Infections  
 Eczema                       Rashes  
 Hives                       Warts

Perspiration (Absent, easily, frequent, night sweats, profuse, on palms of hands and soles of feet)

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**Head, Eyes, Ears, Nose and Throat**

Headaches: Where is the discomfort, forehead, back, top, sides or temple? \_\_\_\_\_

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Dizziness                       Sinus Pain  
 Dry eyes                       Frequent sinus infections  
 Red eyes                       Recurrent sore throat  
 Night blindness                       Sensation of something stuck in throat  
 Cataracts                       Dry nose  
 Glasses/Contacts                       Nose bleeds  
 Spots or floaters                       Grinding teeth  
 Earaches                       Sores on lips, tongue or gums  
 Ringing in ears                       Facial Pain  
 Poor hearing                       Teeth or gum problems  
 Chronic sinus drainage                       Jaw Pain  
 Migraine headaches with nausea

Comments \_\_\_\_\_

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**Cardiovascular**

Irregular heart beat                       Swelling of hands                       Fast pulse (over 100 /minute)  
 Palpitations                       Swelling of feet or ankles                       Slow pulse (less than 60 /minute)  
 Fainting                       Difficulty breathing                       Red or flushed face  
 Cold hands or feet                       Varicose veins

Comments \_\_\_\_\_

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**Respiratory**

Cough                       Difficulty breathing when lying down                       Prone to getting respiratory infections  
 Phlegm                       Shortness of breath with daily activity

Comments \_\_\_\_\_

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**Gastrointestinal**

Describe your appetite (poor, good, excessive, irregular) \_\_\_\_\_

Abdominal distention                       Hemorrhoids                       Ulcer  
 Bad breath                       Indigestion/reflux                       Irritable bowel syndrome  
 Belching                       Nausea                       No appetite for breakfast  
 Constipation                       Rectal pain  
 Diarrhea                       Taste; sour, bitter, sweet, etc  
 Gas                       Vomiting

Abdominal pain or cramps associated with eating? \_\_\_\_\_

Bowel movements; frequency, consistency, color : \_\_\_\_\_

**Genitourinary**

- |   |   |
|---|---|
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Decrease in urine flow     |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Inability to empty bladder |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Kidney stones              |
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Sores on genitals          |

Do you easily get bladder infections? \_\_\_\_\_

Do you wake up at night to urinate? \_\_\_\_\_ How often? \_\_\_\_\_

What color is your urine? \_\_\_\_\_

Does your urine have an odor? \_\_\_\_\_

Other genital or urinary problems: \_\_\_\_\_

**Reproductive / Gynecologic:** Please answer even if you are post-menopausal.

- |  |   |
|--|---|
| <input type="checkbox"/> Age of first menses   | <input type="checkbox"/> Age at menopause             |
| <input type="checkbox"/> Length of cycle       | <input type="checkbox"/> Duration of bleeding /period |
| <input type="checkbox"/> Number of pregnancies | <input type="checkbox"/> Miscarriages                 |
| <input type="checkbox"/> Number of live births | <input type="checkbox"/> Hot Flashes                  |
| <input type="checkbox"/> Number of C-Sections  | <input type="checkbox"/> Infertility                  |

Menstruation: Color \_\_\_\_\_ Amount \_\_\_\_\_  
 Cramps \_\_\_\_\_ Clots \_\_\_\_\_

Premenstrual changes-PMS. Mood swings, breast tenderness, bloating, cramps, cravings, etc \_\_\_\_\_

Are you currently pregnant or planning a pregnancy? \_\_\_\_\_

Have you ever taken Birth Control Pills? \_\_\_\_\_ How long? \_\_\_\_\_

Have you been diagnosed or treated for:  fibroids  ovarian cysts  endometriosis

Have you had:  tubal ligation \_\_\_\_\_(yr)  laproscopic surgery \_\_\_\_\_(yr)

Do you get vaginal yeast infections easily / frequently? \_\_\_\_\_

**Male reproductive:**  vasectomy \_\_\_\_\_(yr)  impotence  premature ejaculation  infertility

Prostate gland problem: \_\_\_\_\_

**Musculoskeletal:** Pain location. Please indicate which side by using **R** for right and **L** for left or **B** for both sides.

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Neck          | <input type="checkbox"/> Lower Back |
| <input type="checkbox"/> Shoulder      | <input type="checkbox"/> Pelvis     |
| <input type="checkbox"/> Elbow         | <input type="checkbox"/> Hips       |
| <input type="checkbox"/> Wrist         | <input type="checkbox"/> Knees      |
| <input type="checkbox"/> Hands/Fingers | <input type="checkbox"/> Ankles     |
| <input type="checkbox"/> Upper Back    | <input type="checkbox"/> Feet/Toes  |
| <input type="checkbox"/> Mid Back      |                                     |

Describe the problem, nature and quality of the pain, disabilities and the limitations you experience due to this/these problems. \_\_\_\_\_

**Additional information** you would like us to be aware of: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_