QiBo Acupuncture Patient History

Name (last, middle, first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_ M \_ F \_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital/relationship status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children? \_\_\_\_\_\_\_\_\_\_ How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last receive healthcare? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or is there any possibility that you could be pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any chronic infectious disease? If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Has your case been referred to an attorney (work comp, personal injury or motor vehicle injury claim, etc.)? Y N (please circle)

What are your most important health concerns?

Condition Past Treatments

a. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalization and Surgery**

What hospitalization or surgeries have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**X-rays and Special Studies**

What diagnostic imaging studies have you had? (please circle)

Electrocardiogram Electroencephalogram Mammogram CT scan

X-rays MRI Bone Density Scan Other

**Medications and Supplements**

Please list medications, supplements, vitamins, or herbs that you currently take. Include dosages.

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

Please circle any of the following medications that you currently take:

Pain Relievers (Aspirin, Tylenol, Ibuprofen) Thyroid Medication Diet/Appetite suppressants Birth Control Pills

Cortisone (cream or pills) Hormone Replacement Therapy Sleeping pills Antacids (Tums or Rolaids)

Tranquilizers Laxatives Antidepressants

**General**

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past Maximum Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (when?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

Do you have allergies to drugs or other substances, food sensitivities, allergens in your environment (dust, pollen, mold, animal dander)?

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Immunizations**

Please place a check next to any of the following immunizations that you have received: (please check)

\_\_ Measles/Mumps/Rubella \_\_ Diphtheria \_\_ Pertussis \_\_ Tetanus

\_\_ Polio \_\_ Hepatitis A \_\_ Hepatitis B \_\_ Seasonal Flu

\_\_ H1N1 \_\_ Chickenpox/Herpes Zoster \_\_ Gardasil

\_\_ Other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood Illnesses**

Have you had the following illnesses? (please circle)

Measles Y N

Mumps Y N

Chickenpox Y N

German Measles Y N

Scarlet Fever Y N

Diphtheria Y N

Rheumatic Fever Y N

Other (please explain) ­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Please place a check next to any of the following conditions that you or your family members have experienced:

Arthritis \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

High Blood pressure \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Heart disease \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Diabetes \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Stroke \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Cancer \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Epilepsy \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Asthma \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Hayfever/Hives \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Mental Illness \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Tuberculosis \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Heart Murmur \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Goiter \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Ulcer \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Gallbladder disease \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Liver disease \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Kidney disease \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Anemia \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Glaucoma \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

Cataracts \_\_ self \_\_ mother \_\_ father \_\_ sister \_\_ brother \_\_ children

**Review of Systems:**

Please circle the response that applies. Y = a current condition, P = a past condition, N = a condition you never had.

**Energy and Immunity**

Fatigue Y P N

Itching Y P N

Fullness Y P N

Chronic Infections Y P N

Slow wound healing Y P N

Fibromyalgia Y P N

Chronic Fatigue Syndrome Y P N

**Skin**

Rashes Y P N

Eczema, hives Y P N

Itching Y P N

Acne Y P N

Psoriasis Y P N

**Head**

Headache Y P N

Head Injury Y P N

**Eyes**

Impaired vision Y P N

Glasses or contacts Y P N

Tearing or dryness Y P N

Eye pain Y P N

Glaucoma Y P N

Cataracts Y P N

**Ears**

Impaired hearing Y P N

Ringing Y P N

Earache Y P N

Dizziness Y P N

Loss of balance Y P N

Itching Y P N

Fullness, crackling Y P N

**Nose and Sinuses**

Frequent colds Y P N

Hay fever/allergies Y P N

Nose bleeds Y P N

Sinus problems Y P N

**Mouth and Throat**

Frequent sore throat Y P N

Hoarseness Y P N

Sore tongue Y P N

Gum problems Y P N

Dental cavities Y P N

TMJ disorder Y P N

**Neck**

Lumps Y P N

Swollen glands Y P N

Goiter Y P N

Pain/stiffness Y P N

**Respiratory**

Cough Y P N

Sputum Y P N

Spitting up blood Y P N

Asthma Y P N

Bronchitis Y P N

Pneumonia Y P N

Pleurisy Y P N

Emphysema Y P N

Difficulty breathing Y P N

Pain on breathing Y P N

Shortness of breath Y P N

At night Y P N

Lying down Y P N

Tuberculosis Y P N

**Cardiovascular**

Heart disease Y P N

Angina Y P N

High blood pressure Y P N

Low blood pressure Y P N

Murmurs Y P N

Palpitations Y P N

Anemia Y P N

Chest pain Y P N

Swelling in ankles Y P N

**Gastrointestinal**

Heartburn Y P N

Difficulty swallowing Y P N

Change in thirst Y P N

Change in appetite Y P N

Nausea Y P N

Vomiting Y P N

Vomiting blood Y P N

Bowel movements

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a change? \_\_\_\_ Y \_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_

Blood in stool Y P N

Belching or passing gas Y P N

Jaundice (yellow skin) Y P N

Liver disease Y P N

Hemorrhoids Y P N

Gallbladder disease Y P N

Constipation Y P N

Diarrhea Y P N

Abdominal pain Y P N

Gluten intolerance Y P N

**Urinary**

Pain on urination Y P N

Increased frequency Y P N

Frequency at night Y P N

Inability to hold urine Y P N

Frequent infections Y P N

Kidney stones Y P N

Blood in urine Y P N

**Female Reproductive**

Age menses began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of days menstrual bleeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding between periods Y P N

Are cycles regular Y P N

Pain during intercourse Y P N

Painful menses Y P N

Excessive flow Y P N

Birth control Y P N

What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty conceiving Y P N

PMS Y P N

Menopausal symptoms Y P N

Vaginal discharge Y P N

Venereal disease Y P N

Pelvic pain Y P N

Breast pain or tenderness Y P N

Breast lumps Y P N

Nipple discharge Y P N

**Male Reproductive**

Hernias Y P N

Testicular masses Y P N

Testicular pain Y P N

Prostate disease Y P N

Venereal disease Y P N

Discharge or sores Y P N

Sexual difficulties Y P N

**Musculoskeletal**

Joint pain/stiffness Y P N

Arthritis Y P N

Broken bones Y P N

Muscle spasms/cramps Y P N

Weakness Y P N

Fibromyalgia Y P N

**Peripheral Vascular**

Deep leg pain Y P N

Cold hands/feet Y P N

Varicose veins Y P N

Thrombophlebitis Y P N

Easy bleeding/bruising Y P N

**Neurological**

Fainting Y P N

Seizures Y P N

Paralysis Y P N

Muscle weakness Y P N

Numbness or tingling Y P N

Shooting pains Y P N

Loss of memory Y P N

**Emotional/Behavioral**

Depression Y P N

Anxiety Y P N

Mood swings Y P N

Excessive anger Y P N

Mania Y P N

ADHD Y P N

Obsessive-Compulsive Y P N

**Endocrine**

Hypothyroid Y P N

Hyperthyroid Y P N

Hypoglycemia Y P N

Diabetes Y P N

Heat or cold intolerance Y P N

Excessive thirst Y P N

Excessive hunger Y P N

Sweats Y P N

**Lifestyle**

Please describe your typical food and beverage intake:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Y P N

How many days per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat three meals daily? Y P N

Do you awaken rested? Y P N

Do you sleep well? Y P N

How many hours of sleep do you receive at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your work? Y P N

Do you spend time outside? Y P N

Nicotine and Tobacco use per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol consumption per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine consumption per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for alcoholism or drug dependence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify the information I have supplied is correct and accurate to the best of my knowledge.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_