Health History

Date:__________

Patient Name: ____

Date of Birth:__/__/___ Age:___

Sex at Birth(optional):______________ Current Gender Identity (optional):____________

Address:__________________________ City:_______________ State:_____ Zip:__________

Primary Phone #: ______________________ E-Mail:________________________________

Emergency Contact and Phone #:____

Please complete the following information as it allows me to better understand you and help you meet all your healthcare needs. This information is a part of your medical record and will be protected.

Place of Birth:_______________________

General Birth History:_________________

____

Marital Status:_______________________

Occupation:__________________________

Hobbies:_____________________________

____

____

Exercise Routine:_____________________

____

____

Usual Weight:______ Ideal Weight:_______

Date of last Eye Exam:_____________________

Date of last Dental Exam:___________________

Date of last Physical Exam:_________________

Name of Primary Care Provider (PCP):_________

____

PCP Phone #:______________________________

Any history of family violence/abuse:_________

Please list all known allergies(food,drugs,topical, environmental, etc.):_________________________

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Lifestyles:

1) Smoking (type & amount/day):_____
   ____
2) If former smoker, date quit:_________
3) Alcohol (type & amount/day):______
   ____
4) Caffeine(type & amount/day):______
   ____
4) Other Recreational Substances (type & amount/day):______________
   ____

Please list all serious illness, operations, and hospitalizations you have experienced with the year they occurred: ________________________
____
____
____
____
____
____

Please list all motor vehicle accidents, sport injuries, and broken bones with the year they occurred:_______________________________________
____
____
____

Have you currently been diagnosed or are experiencing any of the following? (circle or √)

Infectious Diseases:
Measles
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever
Diphtheria
Small Pox
Rheumatic Fever
Polio
Tuberculosis
Mono
AIDS or HIV +
Hepatitis

Respiratory:
Asthma
Bronchitis
Pneumonia
Sleep Apnea
COPD
Emphysema
Shortness of Breath
Wheezing
Chronic Cough
Persistent Hoarseness
Sinus Problems
Difficulty Inhaling
Difficulty Exhaling
Bloody Sputum

Cardiovascular:
Heart Disease
High Cholesterol
High Blood Pressure
Low Blood Pressure
Irregular Heart Beat
Palpitations/Flutters
Mitral Valve Prolapse
Heart Murmur
Chest Pain
Blood Clots
Purple finger/toes
Swelling
Cold hand/feet
Enlarged Veins

Neurological:
Epilepsy
Stroke
Poor Memory
Alzheimer's
Concussion
Traumatic Head Injury

Digestive:
Ulcers
Acid Reflux
Ulcerative Colitis
Gastroenteritis
Celiac Disease
Crohn's Disease
IBS
Diverticulitis
Parasitic Infection
Frequent Belching
Abdominal Cramping
Nausea/Vomiting
Chronic Diarrhea
Chronic Constipation
Vomiting Blood

Black/Tarry Stools
Hemorrhoids
Rectal Bleeding
Gallbladder stones
Fatty Liver
Liver Cirrhosis

Skin and Hair:
Eczema
Psoriasis
Acne
Dandruff
Alopecia/ Hair loss
Fungal Infections
Rashes/Hives
Yellow/Jaundice Skin
Bruise Easily
Sudden Changes in Nails/Hair
Temperature Sensitivity
Numbness/ Tingling

Urinary:
Bladder Discomfort/Pain
Kidney Stones
Kidney Disease
Dark Urine
Cloudy Urine
Frequent Urination- Day/Night
Painful Urination
Leakage of Urine
Urinary Urgency
Difficulty Starting a Stream
Blood In Urine
Bladder Infection
Bladder Prolapse
Excessive thirst
Loss/Lack of thirst

Musculoskeletal:
Arthritis
Fibromyalgia
Back/Disc/Spine Problems
Knee Problems
Bone Loss/Weakness
Muscle Weakness
Muscle Cramps/Spasms
Stiff Joints
Swollen Joints
Paralysis

Neuropsychological:
Seizures
Neuropathy
Tics
Poor Memory
Depression
Anxiety
Bipolar
Suicidal
Addiction
Enrolled/Completed Rehab
Seeing Counselor/Psychotherapist
Sleeplessness/ Insomnia
Difficulty Falling Asleep
Waking early
Vivid or Disturbing Dreams
Poor Coordination
Dizziness
Fainting
Vertigo

HEENT:
Headaches/Migraines
Double Vision
Blurred Vision
Eye Pain
Eye Infection /Eye Discharge
Use of Corrective Lenses
Eye Floaters
Ringing in Ears
Discharge from Ears
Ear Pain
Hearing Loss
Nose Bleeds
Loss of Smell
Sore Throat
Sores on Tongue or Gums
Bleeding Gums

General:
Anemia
Diabetes
Low Blood Sugar
Reactive Hypoglycemia
Cancer
Glaucoma
Blood or Plasma Transfusions
Thyroid Disease
Liver Disease
Adrenal Disease
Persistent Fevers
Change in Appetite
Weight gain/loss
Tire Easily
Chronic Fatigue
Others:_____________________________
____
____

Genital (Males only):
Increased/Decreased libido
Impotence
Erectile Dysfunction
Premature Ejaculation
Nocturnal Emissions
Penile Pain
Discharge
Testicular Pain or Lump
Impotence
Infertility

Gynecological (Females only):
PMS
PCOS
Hysterectomy/Uterine Prolapse
Elective/Spontaneous Abortion
Miscarriage
Infertility
Venereal Disease
Cervical Dysplasia
Vaginal Infection/Vaginitis
Hot Flashes
Night Sweats

Increased/Decreased Sex Drive	(Females Only):	Current Birth Control Method:
Breast Lumps or Swelling	Age Menses Started:_______________	_____________________________________
Breast Pain	Current length of cycle	Number of Pregnancies:___________
Pain with Intercourse	(Day 1 to Day 1):__________________	Number of Live Births:_____________
Spotting Between Periods	Current length of Menses	Age of Menopause:__________
Painful Menses/ Cramps	(days):___________	
Painful/Swollen Breasts with Periods	First day of last period: _____________	
Emotional Outbursts with Periods	Describe Flow:	
	_________________________________	
Please Provide the following	Size of Clots:______________________	
information about your Menstrual	Date of Last Pelvic Exam:___________	
Cycle and Gynecological Health	Date of Last Mammogram:__________	

Family History:

Has any blood relative had problems or been diagnosed with any of the following:
(please circle if yes and indicate the relative's relation to you)

	Relation		Relation
Cancer	_________________	Diabetes	_________________
Heart Disease	_________________	High Blood Pressure	_________________
Stroke	_________________	Epilepsy	_________________
Allergies	_________________	Anemia	_________________
Bleeding	_________________	Asthma	_________________
Addiction	_________________	Depression	_________________
Psychosis	_________________	Suicide	_________________
Leukemia	_________________	Migraines	_________________
Obesity	_________________	Thyroid issues	_________________
High Cholesterol	_________________	Kidney Disease	_________________
Glaucoma	_________________	Gout	_________________
Others	_________________		

Your Diet: (circle all that applies)

I crave: spicy sweet pungent salty sour

I would describe my appetite as being: low average/moderate high extreme none

I enjoy the following sweets: soda sugar artificial sweeteners

I enjoy fast food: never sometimes frequently daily

I enjoy organic foods: never sometimes frequently daily

My water intake is: 1-3 4-6 6-8glasses/day

Average daily menu (please honestly describe your food intake during one day)

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Please List all Pharmaceuticals and Supplements you currently take with dosages:

____

____

____

____

____

____

____

CHIEF COMPLAINT (Please list your top three health concerns, signs, or symptoms):

____

____

____

To the best of my knowledge the questions answered and information provided on the above pages is accurate. I understand that providing incorrect information can hinder my healthcare and treatment. I accept responsibility for informing Billy Che Quintana L.Ac./ **Vibrant Pearl Acupuncture & Herbs** of any changes in my medical status and health.

Signature____ Date_______________

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