**HEALTH HISTORY FORM**

Artemis Acupuncture & Herbs

**PATIENT AND DEMOGRAPHIC INFORMATION**

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

Legal name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pronouns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information:

\*I will never send protected health information over any sort of communication form without your explicit consent in-advance. These methods of communication will primarily be utilized for purposes such as scheduling and payment. Please see Notice of Privacy Practices for more details.

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ It is okay to leave messages at this number?

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to send emails to this address?

Home address Is it okay to send mail to this address?

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zipcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician

 Name

Location

Phone number

Emergency contact

 Name

 Relationship to patient

Phone number

**SOCIAL HISTORY + LIFESTYLE**

Are you currently working?

If yes, what do you do?

Occupational stress (physical, chemical, psychological, etc.)

Do you have a regular exercise program? Please describe

Have you ever been on a restricted diet? Please describe

Please describe your average daily diet (#of meals, content of meals, etc.)

Tobacco: how many packs per day?

Caffeine (coffee, tea, energy drinks, etc.): how many cups per day?

Alcohol: how many drinks per week?

Non-prescription/recreational drug use:

Medications and Supplements you are taking:

|  |  |
| --- | --- |
| Name of medication/supplement | Reason for taking |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |

Allergies (drugs, chemicals, foods, etc.)

**HEALTH INFORMATION**

Have you been treated with acupuncture or Traditional East Asian Medicine before? Y/N

Primary concern

How long ago did this problem begin?

To what extent does this problem interfere with your daily activities (work, sleep, leisure, etc.)?

Have you been given a diagnosis for this problem?

What other treatments (if any) have you tried to address this problem?

Secondary concern

How long ago did this problem begin?

To what extent does this problem interfere with your daily activities (work, sleep, leisure, etc.)?

Have you been given a diagnosis for this problem?

What other treatments (if any) have you tried to address this problem?

Any other concerns that you would like to address?

**Past Medical history**

|  |  |
| --- | --- |
| Surgeries (including significant dental work) | Date |
|   |   |
|   |   |
|   |   |
|   |   |
|  |  |

|  |  |
| --- | --- |
| Significant trauma (accidents, falls, injuries, etc.) | Date |
|   |   |
|   |   |
|   |   |
|   |   |
|  |  |

**FAMILY MEDICAL HISTORY**

|  |  |
| --- | --- |
| **Condition** | **Family member**  |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|   |   |
|  |  |
|  |  |
|  |  |

**Please check “Current” for any symptoms you have had in the last three months and “Past” for any conditions that you have had at any point in your life but are not currently dealing with:**

**General** Current Past

|  |  |  |
| --- | --- | --- |
| Unexplained weight loss  |   |   |
| Unexplained weight gain |   |   |
| Increased appetite |   |   |
| Decreased appetite |   |   |
| Strong thirst |   |          |
| Thirst with no desire to drink  |   |   |
| Peculiar tastes or smells |   |   |
| Recent fevers or sweating |   |   |
| Recent chills or cold sweats |   |   |
| Do not sweat |   |   |
| Sweat easily  |   |   |
| Nighttime sweating |   |   |
| Unexplained fatigue or weakness |   |   |
| Easy bruising or bleeding  |   |   |
| Trouble sleeping  |   |   |
| Sudden energy crash during the day  |   |   |
| Cancer          What type? |   |   |
| Anemia  |   |   |
| Blood/bleeding disorder  |   |   |
| Chronic fatigue |   |   |
| Genetic condition What condition? |   |   |

**Endocrine** Current Past

|  |  |  |
| --- | --- | --- |
| Dislike the cold |   |   |
| Dislike the heat |   |   |
| Increased thirst |   |   |
| Increased appetite |   |   |
| Hypothyroid |   |   |
| Hyperthyroid |   |   |
| Diabetes type I |   |   |
| Diabetes type II |   |   |

**HEENT** Current Past

|  |  |  |
| --- | --- | --- |
| Change in hearing |   |   |
| Ringing in the ears |   |   |
| Pain in the ears  |   |   |
| Congestion |   |   |
| Sinus pain |   |   |
| Sore throat |   |   |
| Bloody noses  |   |   |
| TMJ  |   |   |
| Teeth grinding or clenching  |   |   |
| Dental problems  |   |   |
| Sores on lips or tongue  |   |   |
| Facial pain  Where?  |   |   |
| Change in vision |   |   |
| Floaters |   |   |
| Night blindness  |   |   |
| Eye pain  |   |   |
| Cataracts |   |   |
| Glaucoma |   |   |
| Macular degeneration  |   |   |
| Ocular hypertension |   |   |
| Retinal detachment  |   |   |

**Immune** Current Past

|  |  |  |
| --- | --- | --- |
| Allergies  |   |   |
| Autoimmune condition What condition?  |   |   |
| Mononucleosis  |   |   |
| HIV |  |  |

**Respiratory** Current Past

|  |  |  |
| --- | --- | --- |
| Frequent colds or coughs  |   |   |
| Coughing |   |   |
| Coughing blood |   |   |
| Phlegm production |   |   |
| Wheezing/asthma  |   |   |
| Shortness of breath         When lying down? |   |   |
| Pain with breathing         |   |   |
| Sleep apnea |   |   |
| Snoring  |   |   |
| Asthma |   |   |
| Bronchitis |   |   |
| COPD |   |   |
| Emphysema  |   |   |
| Sleep apnea |   |   |
| Pneumonia |   |   |
| Pulmonary embolism  |   |   |
| Tuberculosis  |   |   |

**Cardiovascular** Current Past

|  |  |  |
| --- | --- | --- |
| Chest pains or discomfort |   |   |
| Palpitations  |   |   |
| Decreased exercise toleranceAre you able to walk two flights of stairs without stopping? |   |   |
| Swelling of hands |   |   |
| Swelling of feet  |   |   |
| Heart murmur |   |   |
| Irregular heartbeat  |   |   |
| Heart attack/MI |   |   |
| Pacemaker  |   |   |
| Hypertension (high blood pressure) |   |   |
| Hypotension (low blood pressure)  |   |   |
| Congestive heart failure  |   |   |
| Coronary atherosclerosis  |   |   |
| Blood clot Where? |   |   |
| Arteriosclerosis |   |   |
| High cholesterol  |   |   |

**Gastrointestinal** Current Past

|  |  |  |
| --- | --- | --- |
| Heartburn/indigestion |   |   |
| Belching  |   |   |
| Nausea  |   |   |
| Vomiting |   |   |
| Pain in abdomen |   |   |
| Diarrhea |   |   |
| Constipation |   |   |
| Hemorrhoids  |   |   |
| Change in bowel movements (frequency, consistency, color) |   |   |
| Blood in stools  |   |   |
| GERD |   |   |
| Ulcer (gastric or duodenal) |   |   |
| Hepatitis  |   |   |
| Crohn's  |   |   |
| IBS |   |   |
| Ulcerative colitis |   |   |
| Diverticulitis |   |   |
| Hernia  |   |   |
| Gallstones  |   |   |
| Appendicitis  |   |   |
| Gastrointestinal cancer  |   |   |
| Hepatitis (A/B/C/D) |   |   |

**Genitourinary** Current Past

|  |  |  |
| --- | --- | --- |
| Painful urination |   |   |
| Cloudy urine |   |   |
| Bloody urine |   |   |
| Leaking urine |   |   |
| Nighttime urination  How frequently? |   |   |
| Discharge from genitals  |   |   |
| Concerns with sexual functions |   |   |
| UTI (how frequently?) |   |   |
| Kidney stones  |   |   |
| Incontinence  |   |   |
| STI |   |   |
| Prostate problems  |   |   |

|  |  |
| --- | --- |
| Are you sexually active?  |   |
| Do you use any birth control method(s)? |   |
| What type(s) and for how long? |   |

**Gynecological + Obstetrics**

|  |  |
| --- | --- |
| Age at first menstrual period |   |
| First day of last menstrual period  |   |
| Duration of menstrual period |   |
| Length of menstrual cycle (# of days from the start of one period until the start of the next period)  |   |
| # of pregnancies |   |
| # of births |   |
| # of vaginal births |   |
| # of C-sections |   |
| # of premature births |   |
| # of miscarriages |   |
| # of abortions |   |
| Unusual vaginal bleeding  |   |
| Date of last pap exam  |   |
| Date of last mammogram  |   |

**Menstruation details** Current Past

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Cramps

|  |  |
| --- | --- |
| None |   |
| Mild |   |
| Moderate |   |
| Severe |   |

 |   |   |
| Other pain Where? |   |   |
| Flow

|  |  |
| --- | --- |
| Light |   |
| Moderate |   |
| Heavy |   |
| Spotting between periods?  |   |

  |   |   |
| Clots

|  |  |
| --- | --- |
| None |   |
| Some |   |
| Many  |   |

 |   |   |

**Premenstrual symptoms** Current Past

|  |  |  |
| --- | --- | --- |
| Pain  Where? |   |   |
| Breast distension |   |   |
| Headache |   |   |
| Mood changes |   |   |
| Digestive changes  |   |   |

**Dermatology** Current Past

|  |  |  |
| --- | --- | --- |
| Rash |   |   |
| Hives  |   |   |
| Change in hair or skin (texture, color, etc.) Where? |   |   |
| New mole or significant change in an existing mole |   |   |
| Hair loss  Where? |   |   |
| Hair growth  Where? |   |   |
| Pimples/acne  Where?  |   |   |
| Eczema  |   |   |
| Psoriasis  |   |   |
| Alopecia  |   |   |
| Skin cancer  |   |   |
| Dandruff  |   |   |
| Acne  |   |   |

**Musculoskeletal**

(please indicate location) Current Past

|  |  |  |
| --- | --- | --- |
| Muscle pain |   |   |
| Joint pain |   |   |
| Weakness  |   |   |
| Swelling  |   |   |
| Stiffness  |   |   |
| Arthritis |   |   |
| Osteoporosis  |   |   |
| Fibromyalgia  |   |   |

**Neurological** Current Past

|  |  |  |
| --- | --- | --- |
| Memory loss |   |   |
| Headaches |   |   |
| Migraines |   |   |
| Concussion  |   |   |
| Dizziness  |   |   |
| Fainting |   |   |
| Tremors  Where?  |   |   |
| Loss of balance |   |   |
| Numbness or tingling  Where?  |   |   |
| Weakness  Where?  |   |   |
| Stroke

|  |  |
| --- | --- |
| Ischemic |   |
| Hemorrhagic |   |
| TIA |   |

 |   |   |
| Seizures/Epilepsy |   |   |
| Parkinson's  |   |   |
| MS |   |   |
| ALS |   |   |
| Meningitis  |   |   |
| Paralysis  |   |   |

**Psychological/Emotional**  Current Past

|  |  |  |
| --- | --- | --- |
| Depression |   |   |
| Anxiety |   |   |
| Panic attacks |   |   |
| Mood swings  |   |   |
| Stress  |   |   |
| Anger |   |   |
| Substance abuse  |   |   |
| PTSD  |   |   |
| Eating disorder |   |   |