Michigan Associates of
Acupuncture and
Integrative Medicine

Health History Questionnaire

Name_______________________________________ Date__________________

Age_________ Date of Birth__________ Gender__________

Married__ Single__ Separated__ Divorced__ Widowed__ Partnership__

Live with: Spouse__ Partner__ Parents__ Children__ Friends__ Alone__

Please complete these next sections as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

Please list the names of any physicians or medical professionals you work with and what you are seeing them for**.**

Physician	Condition

What are your most important health problems? List as many as you'd like in order of importance.
1.____
2.____
3.____
4.____
5.____
6.____

Hospitalizations and Surgeries

What Hospitalizations, surgeries and tests (MRI, CT scan) have you had?

____
____
____
____
____
____

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Allergies

Are you hypersensitive or allergic to…
Any drugs?_________________________________foods_____________________________

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking. Please share the condition each medication treats and how long you have been taking the medication.

Medication	Condition	Months/years used

Overall Health

How is your sleep____?
How is your energy____?
Are you every dizzy or lightheaded____?
To you tend to be hot or cold____?
When during the day is your energy best?__________________worst?____________

For the Following, Please circle
Y= a condition you have now or **P =** a condition you have had before

Head/Eyes/Neck

Headaches- **Y P**
Migraines- **Y P**
Spots in Eyes-**Y P**
Jaw/TMJ problems- **Y P**
Prior head injury- **Y P**
Ringing in the ears- **Y P**

Respiratory

Frequent colds- **Y P**
Sinus Problems - **Y P**
Shortness of breath- **Y P**
Pneumonia- **Y P**
Phlegm in throat- **Y P**
Asthma - **Y P**
Recurrent Bronchitis- **Y P**
Recurrent Sore Throats- **Y P**
Allergies:____

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Cardiovascular

Heart Disease- **Y P**
High Blood Pressure- **Y P**
Palpitations/Fluttering- **Y P**
Angina- **Y P**
Low Blood Pressure – **Y P**
Chest pain- **Y P**

Gastrointestinal

Bowel movements How often___
is this a change______
Abdominal Pain - **Y P**
Acid Reflux/GERD **– Y P**
Underweight – **Y P**
Normal for Height – **Y P**
Bloating **Y P**
Gas **Y P**
Bloating – **Y P**
Irritable Bowel Syndrome – **Y P**
Overweight – **Y P**
Very Overweight - **Y P**

Genitourinary

Pain on Urination- **Y P**
Frequency at night- **Y P**
Frequent infections- **Y P**
Increased frequency- **Y P**
Kidney Stones- **Y P**
Water retention- **Y P**

Endocrine/Immune

Hypothyroid- **Y P**
Hyperthyroid- **Y P**
Have you been diagnosed with an Autoimmune Disorder? ________________________

Skin

Musculoskeletal

Please tell us about any musculoskeletal issues
____
____
Where do you carry stress in your body?____
____
____

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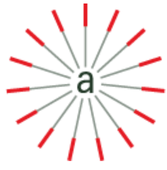

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Sleep

How many hours of sleep do you get on average?______________________
Do you sleep well **Y N** Do you awaken rested? **Y N**

Exercise

Do you exercise? **Y N**
If yes, what kind_________________________How often_________________________

Diet

Do you eat three meals a day **Y N**
Do you drink coffee______
Do you drink cola____

Do you eat out often? **Y N**
Do you eat dairy products _____
Do you eat sugar_____

Diet, Cont.

Tell us a bit about your daily eating habits:
Breakfast____
Lunch-____
Dinner____
Snacks____
Cravings____

Habits

Have you ever been treated for drug dependence? **Y N**
Use recreational drugs? _____
Been treated for alcoholism _____
Smoked previously _____

Use alcoholic beverages ______
Do you use tobacco ______
#packs per day____ # of years___

Lifestyle

Main interests and Hobbies____
How many hours do you watch television? _______________Read? _____________
Take vacations? **Y N** Spend time outside **Y N**
Do you enjoy your work? **Y N**

Spirit

Do you have a religious or spiritual practice? Y N If yes, what?_________________
Are you satisfied with your spiritual life/practice?___________________

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Emotional

Treated for emotional problems- **Y P**
Mood Swings- **Y P**
Often feel angry- **Y P**
Cry Uncontrollably- **Y P**
Have a supportive relationship – **Y P**

Depression- **Y P**
Anxiety or nervousness- **Y P**
Feel Sad often- **Y P**
Irritability- **Y P**
Difficulty concentrating- **Y P**

Any major Traumas?________________________________
Are you currently seeing a psychologist/therapist? ____________________________________

Anything else?____

The above information is true and accurate

____
Signature Date

Thank you for your time

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Gynecological History

Name of Gynecologist____
Age of first menses____________ Date of last menses____________
Are your cycles regular: Y N
Number of days between each cycle_______
Amount of bleeding: heavy medium light
Painful menses: Y N
Clotting during menses: Y N Size of clots: small medium large

PMS Symptoms____
____
Spotting between cycles Y N
When? How long?____
____

Endometriosis: Y N symptoms______________________________________
Fibroids: Y N if yes–how many:____ size: small medium large
Have you been diagnosed with P.C.O.S.? Y N
History of ovarian cysts: Y N

Do you ovulate Y N Early: Y N Late: Y N
Do you experience pain during ovulation Y N
Do you notice cervical mucous during or prior to ovulating Y N

History of yeast infections: Y N if so, how frequent_______________
History of abnormal pap smears: Y N
How is your sex drive?____
Do you conduct self breast exams: Y N
Have you had a mammogram? Y N
Do you have fibrocystic breast disease? Y N
Have you ever used oral contraceptives? Y N
How long? When did you last use them?
____

Are you menopausal or peri-menopausal? Y N

Symptoms____
____

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Gynecological History, cont.

Have you been pregnant before: Y N
How many: pregnancies______________
miscarriages_____________
children_________________

Have you been diagnosed with infertility? Y N
(If Yes, Please continue with the remainder of the questionnaire)

How long have you been trying to have a baby________________________

Have you had ectopic pregnancies: Y N
How many_________ When______________
Are both of your tubes functioning: Y N if no, explain ________________
____

Have you had laparoscopic surgery Y N
Date____________________
Outcome____

Are you receiving care from a fertility specialist: Y N
Name____
How long____

Diagnosis____
____
____

Have you received "alternative medicine" treatment for fertility: Y N
Explain____
____
____
____

Anything else? ____
____
____

The above information is true and accurate

____
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