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Patient Health History Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information clearly and indicate areas of confusion with a question mark.

I. General Patient Information: **Today's Date: _____/_____/________**

First Name:_____________________________ Last Name: ____

Address:____

City:____State:_________Zip:_____________

Date of Birth:_____/_____/_____ Age:________ Height:________ Weight: _______lbs

Gender: M F Marital Status: S M D W

Occupation:____

Phone #: Home:______________________ Work:______________________ Cell:_____________________

Email Address:____

Emergency Contact Name:________________________________ Phone: _____________________________

Relationship:__________________________

Primary Physician Name:____

Address:____ Phone:________________________

II. Current Medical History:

Are you currently under the care of a physician? Y N If yes, for what?_________________________________

Please indicate health concerns that have brought you to Dr. Burgoon, in order of importance:

Condition A:____

How long have you had this condition?____

How did it start? ____

What treatments have you received?____

What seems to make it better? ____

What seems to make it worse? ____

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Condition B: ____

How long have you had this condition?____

How did it start? ____

What treatments have you received?____

What seems to make it better? ____

What seems to make it worse? ____

Condition C: ____

How have you had this condition?____

How did it start? ____

What treatments have you received?____

What seems to make it better? ____

What seems to make it worse? ____

Foods, drugs, or medications you are hypersensitive or allergic to (please indicate reaction):

____

____

Dietary restrictions:____

____

Food cravings:____

Medications (prescribed & over-the-counter), vitamins, & supplements you currently take:

Name	**Dose**	**Purpose**	**How long?**

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Do you have any reason to believe that you are currently pregnant? Yes No

Due date:____________________________

III. Family History:

Please list any medical conditions, disorders or diseases of a hereditary nature in your family, such as cancer, diabetes, heart disease, high blood pressure, mental illness, asthma, etc.:

____
____
____
____
____
____

IV. Past Medical History:

Childhood Illnesses (Circle any that apply):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other: ____

Immunizations (Circle any that apply):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Other:____

Hospitalizations and Surgeries:

Reason	When?	Reason	When?

X-Rays/CAT Scans/MRIs/NMRs/Special Studies:

Reason	When?	Reason	When?

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V. Patient Profile:

General Symptoms (Check any that currently apply):

___Poor/Heavy Appetite
___Cold Hands/Feet
___Dizziness/Vertigo
___Recent Weight Loss/Gain
___Fever/Chills
___Bruise/Bleed Easily
___Tired after Eating
___Sweats Easily
___Lack of Strength
___Frequent Thirst
___Night Sweats
___Muscle Cramps
___Strong like for Hot/Cold Drinks
___Poor Sleep/Insomnia
___Fatigue
___Dream-disturbed Sleep
Other:____

Head, Eyes, Ears, Nose, Throat (Check any that currently apply):

___Poor Vision
___Teeth/Gum Problems
___Excessive Phlegm
___Eye Pain
___TMJ/Jaw Problems
___Sore Throat
___Blurred Vision
___Facial Pain
___Nosebleeds
___Floaters
___Dry Mouth
___Ringing in Ears
___Red/Itchy Eyes
___Sinus Problems
___Poor Hearing
___Tearing/Dry Eyes
___Earaches
___Headaches/Migraines
___Glaucoma
Other:____

Respiratory (Check any that currently apply):

___Difficulty Inhaling/Exhaling
___Wet/Dry Cough
___Cough with Phlegm
___Shortness of breath
___Chest Tightness
___Color of Phlegm
___Asthma
Other:____

Cardiovascular (Check any that currently apply):

___High/Low Blood Pressure
___Palpitations
___Chest Pain
___Difficulty Breathing
___Swelling of Hands/Feet
___Varicose Veins
Other:____

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Gastrointestinal (Check any that currently apply):

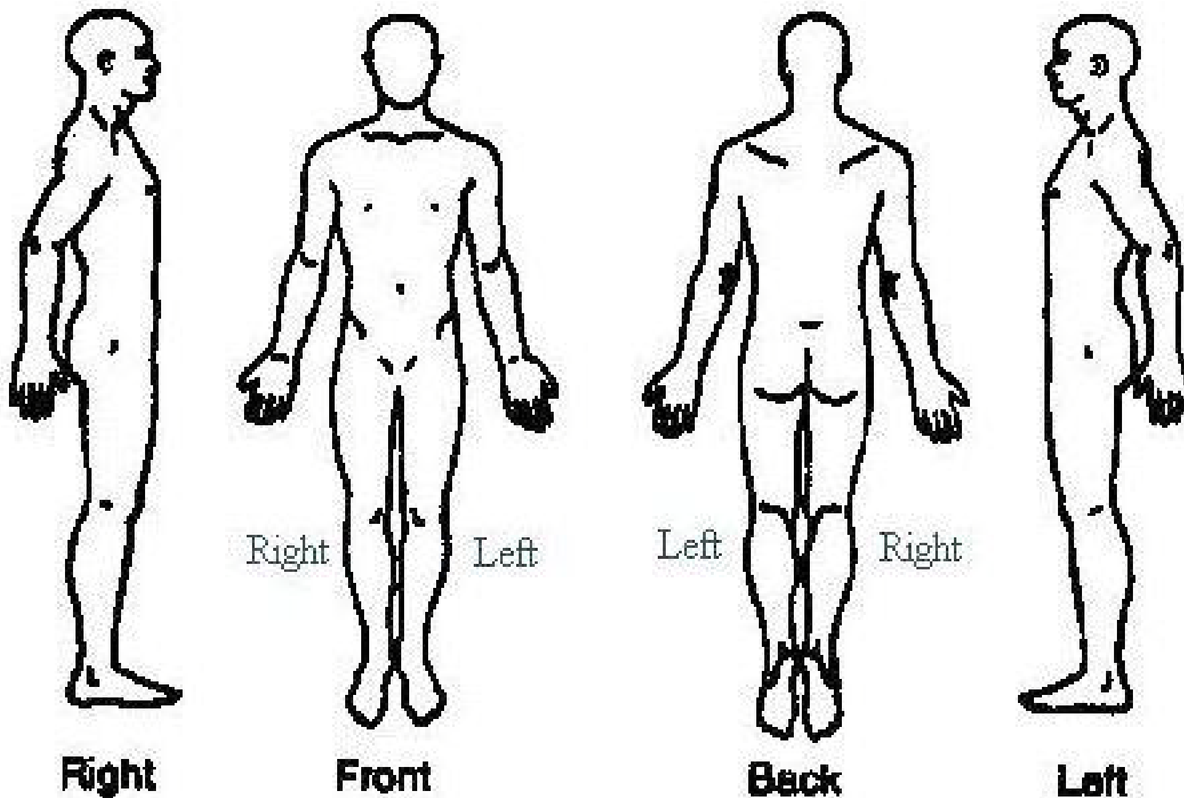
___Nausea	___Gas/Flatulence	___Diarrhea
___Vomiting	___Bloating/Distention	___Constipation
___Acid Reflux/Heartburn	___Bad Breath	___Mucus/Blood in Stools
___# of Bowel Movements/Day	Other:____	

Endocrinal (Check any that currently apply):

___Hypothyroid	___Hyperthyroid	___Hypoglycemia
___Diabetes	___Night Sweats	___Feeling Hot/Cold

Musculoskeletal

On the following diagram, shade in the areas that you feel should be addressed:



Describe the location of your pain/tenderness/tightness:____

____

The pain is (check all that apply):

___Dull ___Sharp ___Stabbing ___Aching ___Numb ___Burning ___Deep

___Tingling ___Superficial ___Comes/Goes Other:____

Circle, as applicable:

Pain is Worse/Better with Heat
Pain is Worse/Better with Cold
Pain is Worse/Better with Pressure
Pain is Worse in the Morning/Evening
Pain is Worse/Better with Rest
Pain is Worse/Better with Movement or Activity

I have (check all that apply):

___Swollen Joints ___Arthritis ___Joint Pain ___Tendonitis ___Rheumatism ___Bone Pain

___Muscle Cramping ___Muscle Pain ___Repetitive Sprain Injury Other:_____________________________

Genito-Urinary Tract (check all that currently apply):

___Painful Urination ___Urgent Urination ___Wake to Urinate

___Frequent Urination ___Blood in Urine ___Difficulty Urinating

____Frequent UTIs Other:____

Hair and Skin (check all that currently apply):

___Rashes/Hives ___Itching ___Dandruff

___Loss of Hair ___Unhealed Sores ___Eczema

___Change in Hair or Skin Texture Other:____

FEMALES: Gynecological (check all that currently apply):

___Infertility ___Breast Tenderness ___Irregular Periods

___Painful Periods ___Vaginal Discharge ___Bleeding between Cycles

___PMS ___Heavy Flow ___Menopausal Symptoms

___Clotting Other:____

FEMALES: Menstrual/Birthing History:

Age of First Menses:_______________
# of Pregnancies:____________
# of Days of Menses:_______________
# of Miscarriages:___________
Length of Cycle:___________________
# of Abortions:______________
Birth Control Type:_________________
# of Live Births:_____________
Age of Menopause:_________________
# of Children:_______________

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FEMALES: Do you experience any pre-menstrual syndrome (PMS), such as migraines/headaches, tender breasts, water retention, food cravings, irritability, depression, joint/muscle pain?

Explain:____

____

MALES: Reproductive System (check any that currently apply):

___Swollen Testes ___Testicular Pain ___Impotence

___Feeling of Cold in External Genitalia ___Feeling of Numbness in External Genitalia

___Premature Ejaculation ___Nocturnal Emissions ___Sexual Difficulties

Other:____

Neuropsychological (check all that currently apply):

___Anxiety ___Depression ___Poor Memory

___Irritability ___Seizures ___Stress

___Mood Swings ___Nervousness ___Mental Tension

___Difficulty Concentrating ___Numbness/Tingling ___Dyslexia

___Fatigue Other:____

Lifestyle, Exercise, Diet, & Energy:

Describe your Level of Energy:____

What Time of the Day is your Energy the Highest?___________________ Lowest?_____________________

Do you Fatigue Easily? Yes No What Makes you Tired?___________________________________

What Type of Exercise do you do and How Often? _______________________________________

____

____

Do you: ___Smoke Cigarettes ___Smoke Marijuana ___Smoke Cigars ___Drink Alcohol ___Other

If Yes, How Often? How Much? ____

Describe your Typical Sleeping Patterns:____

How Many Hours/Night do you Sleep? ___________

Do you Wake to Urinate? Yes No How Many Times? ___________ At What Time?________________

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Do you Wake up Rested? ________________

Do you Have Difficulty: ____Falling Asleep ____Staying Asleep

Do you Snore? Yes No

Do you Typically eat 3 Meals per Day? Yes No If No, How Many:__________________________

Describe your Appetite and Cravings: ____

____

Eat Meat? Yes No Frequency:______________

Eat Sugar? Yes No Frequency:______________

Eat Dairy? Yes No Frequency:______________

Average Daily Menu (Indicate times and types of things you eat):

Breakfast ____

Morning Snack ____

Lunch ____

Afternoon Snack ____

Dinner ____

Nighttime Snack ____

How did you hear about Medical Acupuncture of Chester County?

____

If referred, name? ____