

The People's Medicinesm
Acupuncture and Holistic Wellness Center
559 South Duncan Ave. Clearwater, FL 33756
727-455-7362 www.thepeoplesmedicine.net

Patient Health History

Name: _____ Date: ____/____/____
(First) (Middle) (Last)

Date of Birth: ____/____/____ Age: _____ Gender: M/F Marital status: S M D W

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. Please print clearly. Thank you.

1. When and where did you last receive health care? _____

*For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you in for treatment (please list in order of importance):

Condition

Past Treatment

- a. _____
- b. _____
- c. _____

4. If applicable, please list any foods, drugs, or medications you are **hypersensitive** or **allergic** to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Are you currently suffering from any chronic illness? Y N if yes, please explain _____

9. **Significant diseases, injuries, accidents, hospitalizations, surgeries, X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason

When

Reason

When

10. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

11. **Blood Pressure:** What is your most recent blood pressure reading? ____/____/____ When was this reading taken? _____

12. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

13. **Immunizations** (please circle any that you have had):

Polio Measles/Mumps/Rubella Diphtheria/Pertussis/Tetanus Hib(Influenza B) Hepatitis B Others: _____

14. **Family History:**

	Father	Mother	Siblings	Children
Age (if living)				
Health (G = good, P = poor)				
Age at death (if deceased)				
Cause of death				
Check off family illnesses	Father	Mother	Siblings	Children
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				
Asthma/Hay fever/ Hives				
Kidney Disease				
Other				

15. **Emotional** – please circle any that you are experiencing currently.

Mood Swings Depression Anxiety Mental Tension Nervousness Past Traumas: _____

16. **Energy and Immunity** – please circle any that you are experiencing currently.

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Other: _____

17. **Head, Eye, Ear, Nose, and Throat** – please circle any that you are experiencing currently.

Ear ringing Headaches Sinus problems Frequent sore throat TMJ/Jaw problems Allergies Other: _____

18. **Respiratory** – please circle any that you are experiencing currently.

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma Other: _____

19. **Cardiovascular** – please circle any that you are experiencing currently.

Heart Disease Chest Pain High Blood Pressure Palpitations/Fluttering Other: _____

20. **Gastrointestinal** – please circle any that you are experiencing currently.

Nausea/Vomiting Epigastric or Abdominal Pain Heartburn Gall Bladder Disease Liver Disease

Hemorrhoids Chronic Diarrhea Chronic Constipation Blood in Stool Other: _____

21. **Genito-Urinary Tract** – please circle any that you are experiencing currently.

Kidney Disease Painful Urination Blood in Urine Nighttime Urination Incontinence Other: _____

22. **Female Reproductive/Breasts** – please circle any that you are experiencing currently.

Irregular Cycles Bleeding Between Cycles Vaginal Discharge Premenstrual Problems Menopausal Symptoms
 Pelvic pain Infertility Other: _____

23. **Menstrual/Birthing History:**

Age of 1 st Menses		No. of Days of Menses		Days in Cycle		[Cross-hatched area]
No. of Pregnancies		No. of Live Births		No. of Miscarriages		
Type of birth control, if any				No. of Abortions		

24. **Male Reproductive** – please circle any that you are experiencing currently.

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Other: _____

25. **Musculoskeletal** – please circle any that you are experiencing currently.

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Upper / Mid / Low Back Pain
 Joint Pain (if so, where?): _____ Other: _____

26. **Neurologic** – please circle any that you are experiencing currently.

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Stroke Other: _____

27. **Endocrine** – please circle any that you are experiencing currently.

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Night Sweats Hot/Cold Feeling Other: _____

28. **Other** – please circle any that you are experiencing currently.

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Other / Anything else: _____

29. **Lifestyle:**

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily exercise: _____ Sleep: No. of Hours _____ Do you wake rested? Y/N Do you have dreams? Y/N

c. Occupation: _____ Hours per week: _____ Do you enjoy your work? Y/N

d. Nicotine/Tobacco use: _____ Alcohol consumption: _____ Caffeine consumption: _____

e. Have you experienced any major traumas? Y N Please Explain: _____

f. Television/ Reading habits: _____ g. Interests and hobbies: _____

How did you hear about us? _____
Would you like to receive our email newsletter? Y/N **Your Email:** _____