Pacemaker	Metallic Objects	Hemophilia

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TCM Health History Questionnaire

The following questions are to help determine your various health conditions.
All questions in this questionnaire are strictly confidential and will become part of your medical record.

Date of visit:	Last Name:	First Name:	Middle Name:

Date of Birth: (MM/DD/YYYY)	Height:	Weight:	BMI:	Blood Pressure:

Address:

Home Phone Number:	Mobile Phone Number:	May we leave a message on your phone? ☐ Yes ☐ No

May we send an email relating to your visit? ☐ Yes ☐ No	E-mail Address:
Emergency Contact:	Relationship & Phone :

Occupation:

Family Physician:	Date of Last Physical:

How did you hear about us?

• What is the MAIN PROBLEM you would like to resolve / how, when and where did this condition begin?

• Have you ever received a diagnosis for this condition? If so, what was the diagnosis and who made the diagnosis?

• What types of treatments have you tried, if any?

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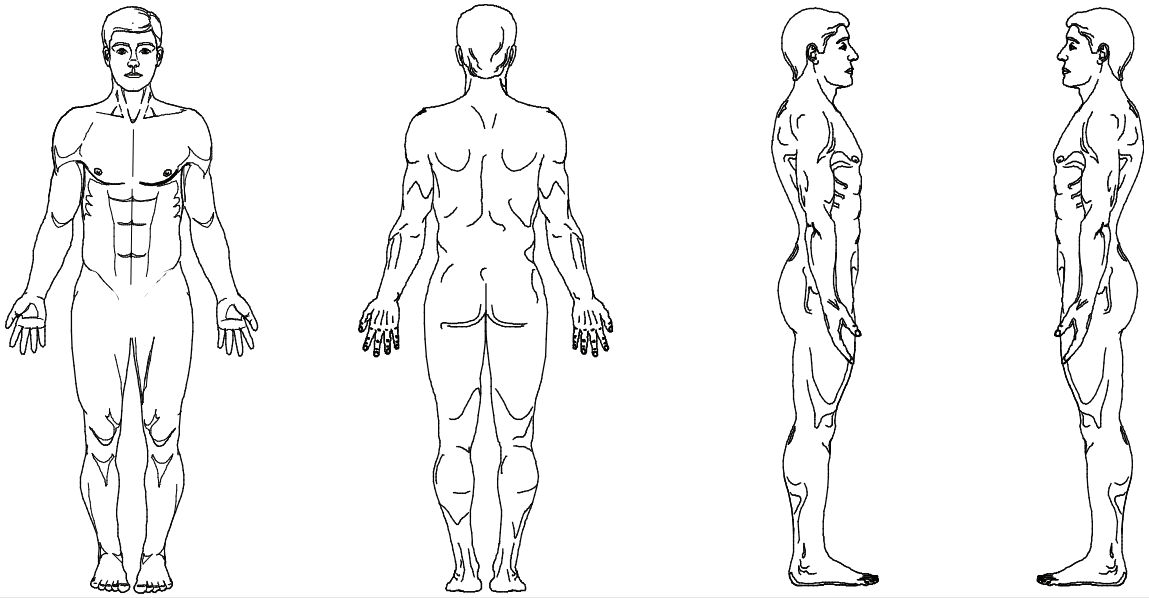
• How does this condition impair daily activities?

• What makes it better or worse?

• If you have any pain or scars in your body, please indicate the location in this chart:



• Please list any health problems you would like to resolve other than the main problem:

1.

2.

3.

• Do you have, or have you ever had any of the following illnesses (Check all that apply):

☐ AIDS	☐ Emphysema	☐ Jaundice	☐ Osteoporosis	☐ Stroke (CVA)
☐ Asthma	☐ FLU	☐ KD Stones	☐ Paralysis	☐ TB
☐ Allergies	☐ Gonorrhea	☐ Migraines	☐ Parasites	☐ Thyroid Disease
☐ Arthritis	☐ Gall Stones	☐ Mumps	☐ Polio	☐ Ulcers
☐ Cancer	☐ High Blood Pressure	☐ Mental Illness	☐ Pneumonia	☐ Venereal disease
☐ Chicken Pox	☐ Heart Disease	☐ Meningitis	☐ Rheumatic Fever	☐ Other
☐ Chronic Fatigue	☐ Hemophilia	☐ Mononucleosis	☐ Shingles	☐
☐ Diabetes	☐ Hepatitis A B C D	☐ Measles	☐ Syphilis	☐
☐ Epilepsy	☐ Herpes	☐ Low Blood Pressure	☐ Seizures	☐

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• Please list Hospitalizations / Surgeries and dates:

1.

2.

3.

• Please list significant physical / mental trauma, auto accidents, falls and dates:

1.

2.

3.

• Please list any medications / vitamins you are currently taking:

Name of Medications	Reason	Duration

• Do you have any allergies? (seasonal, bees, drugs, chemicals, metals, herbs, food, sun, etc.)

• Family Medical History (Check all that apply):

☐ Asthma	☐ Dementia	☐ HIV	☐ Cancer	☐
☐ Allergies	☐ Diabetes	☐ Osteoporosis	☐ Hepatitis	☐
☐ Arthritis	☐ Heart Disease	☐ Seizures	☐ High Blood Pressure	☐
☐ Alzheimer	☐ Thyroid Problems	☐ Stroke	☐ Other	☐

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LIFESTYLE:

• Please describe your average diet:

Breakfast	Lunch	Dinner	Snacks

• How much water do you drink on a daily basis?

• Do you use cigarettes and how often?

• How many alcohol beverages do you drink per week?

• Do you enjoy your work? ☐ Yes ☐ No

• How many hours do you work/week?

• Do you exercise? ☐ Yes ☐ No

• Please describe types of exercise:

• How do you feel after the exercise? Please circle one: Feels better Feels tired Other

• What time do you normally go to bed?

• Do you fall asleep easily? ☐ Yes ☐ No If no, how long does it normally take to fall asleep?

• Do you frequently wake up at night?

• Do you have sleep apnea?

• How is your energy Level (10 is the most energy, please circle one) 1 2 3 4 5 6 7 8 9 10

Signature of Patient_____ Date: / /

Thank you!! You did great on answering so many questions!!