Olde Town Acupuncture & Wellness Center, Inc.

HEALTH HISTORY QUESTIONNAIRE

All Medical History information is confidential.

Name: ______________________________________ Date: ______________________

Address: ____City/Zip________________________

Phone: Home: ________________ Cell: ________________ Work: ________________

Email: ____

Date of Birth: _________________ Height: ________ Weight: ______________

Occupation: ____________________________ Marital Status: __________ Gender: _________

How did you hear about us? ____

Your medical doctor's name and phone number ____

Contact name and phone number in case of emergency _______________________________________

What is your primary reason for this visit?

1)

2)

3)

What initiates your symptoms? ____

What makes them better? ______________________ What makes them worse? ________________

FAMILY HISTORY

Father Living – Age _____ Health Status ____

Deceased – Age at death _____ Cause ____________________________________

Mother Living – Age _____ Health Status ____

Deceased – Age at death ______ Cause ____________________________________

Brother(s) Health Status _____________________________________

Sister(s) Health Status _____________________________________

Children Boy(s) #____ Girl(s) #____ Health Status ______________________________

Check illnesses that have occurred in any of your blood relatives:

Alcoholism	Bleed easily	Diabetes	Heart Disease	Kidney Disease	Obesity
Allergy	Cancer	Epilepsy	High Blood Pressure	Mental Illness	Stroke

Other: ____

PERSONAL HISTORY

Check any illnesses or conditions you have or have had in the past:

AIDS/HIV | Bleed Easily | Heart Disease | Multiple Sclerosis | Shingles
Alcoholism | Cancer | Hepatitis | Night Sweats | Stroke
Allergies | Chicken Pox | High Blood Pressure | Pertussis/Whooping Cough | Thyroid Disorders
Anemia | Diabetes | Jaundice | Pneumonia | Tuberculosis
Antibiotic Use | Epilepsy | Kidney Disease | Polio | Ulcers
Asthma | Glaucoma | Mental Disorder | Rheumatic Fever | Vascular Disease

Other: ____

Do you have a PACEMAKER? Yes No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: ________________________
____
____

Allergies: Are you allergic or hypersensitive to any:

Drugs? ____
Foods? ____
Other? ____

Check the immunizations you have had:

Chicken Pox
Influenza
Other: ___________________________
Diptheria/Pertussis/Tetanus
Measles/Mumps/Rubella
Hepatitis B
Tetanus only

♦ List the Date and Results of last medical test:

Date	Test	Result	Date	Test	Result
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV test			PSA (prostate)	
	Mammography			Stool	
	Other:			Other:	

Current Medications (list all you are taking): ____
____
____
____
____
____
____

Supplements (list all you are taking): ____
____
____
____
____

Typical Food Intake:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Treats: ____

Comments (anything else you would like to tell us):

Patient Signature: ______________________________________ Date: ______________