Health History Questionnaire

Acupuncture & Oriental Medicine of Napa Valley

www.aomNapa.com ~ (707) 418-0010

2180 Jefferson Street, Suite 105, Napa, CA 94559

Patient Information

Full Name _____ Date _____

Primary Address _____ City _____ Zip _____

Preferred phone number _____ Email _____

Date of birth _____ Emergency contact/phone # _____

Relationship _____

Are you currently employed? _____ Occupation _____ Retired _____

Health Insurance Information

This must be submitted to the clinic's medical biller at least 48 hours prior to your treatment

Nancy Guild, Cardinal Business Services ph: 714-944-8162 email: ngbusyone@aol.com

Insurance Company _____ Member ID _____ Group Number _____

Primary subscriber (if different than self) _____

Member Services telephone number (on back of card) _____

Health History

Primary reason for your visit today _____

Date of initial onset? _____ What was the cause, if applicable? _____

Have you received a Western medical diagnosis or treatment related to this concern? If so, please list and describe: _____

Please note degree of severity of your chief complaint today **and** on average:

No problem 1 2 3 4 5 6 7 8 9 10 Worst Possible

Have you had Chinese medicine treatments before? _____ Why: _____

Personal and Family Medical History- please indicate (P) or (F)

___ Allergies
___ Alcoholism
___ Anemia/Blood disorders
___ Arthritic Conditions
___ Asthma
___ Cancer or Tumors
___ Diabetes
___ Eating Disorders
___ Heart Disease
___ Hepatitis/Liver Disease
___ High Blood Pressure
___ Kidney/Bladder Disease
___ Psychiatric Disorders
___ Seizures/Epilepsy
___ Intestinal Disorders
___ Stroke
___ Thyroid
___ Tuberculosis
___ Ulcers
___ Other _____

Surgeries and Hospitalizations- type and date _____

Significant Traumas- type and date _____

Known Allergies- foods, medications, chemical, environmental, etc…

_____

Prescriptions & Supplements

Current medications _____
Have you undergone courses of antibiotics recently? _____ For what? _____
Do you exercise regularly? _____ If so, how often and type? _____
How frequently do you drink alcohol? ___ Daily ___ Weekly ___ Occasionally ___ Never

Please check any of the following you are currently taking or have in the past-
indicate C for current, P for past:
___ Aspirin ___ Antacids ___ Herbs (Western or Eastern) ___ Marijuana ___ Vitamins ___ Caffeine
___ Steroids ___ Analgesics (pain-killers)___ Alcohol ___ Laxatives ___ Anti-inflammatories
___ Psychiatric Drugs ___ Cocaine ___ Amphetamines ___ Tobacco

Please specify vitamins or supplements noted above, or additional information:

_____

Food and Diet

Are you vegan? _____ Are you vegetarian? _____ If so, for how long? _____

Where do you get the majority of your protein consumption? _____

Please list the type of food you eat daily:

_____

Circle the flavors you typically crave: salty sweet spicy sour bitter

Do you experience any of the following symptoms?
Please check all that apply by indicating a C for current, or P for past

General
__ Fatigue
__ Depression
__ Anxiety
__ Irritability
__ Anger
__ Fever and/or chills
__ Recurrent colds or flu
__ Recurrent infections
__ Thirst (for cold or hot?)
__ Feel cold or hot
__ Nightsweats
__ Sweat easily
__ Sudden change in weight

Sleep
__ Insomnia
__ Difficulty falling asleep
__ Wake up during night
times per night? _____

Skin/Hair/Nails
__ Acne
__ Dry skin
__ Dry/brittle hair
__ Warts
__ Eczema
__ Change in mole
__ Rashes/hives
__ Dry/brittle nails
__ Hair loss/thinning

HEENT
__ Headaches
where: _____
frequency: _____
__ Migraines
__ Dizziness/vertigo
__ Earache
__ Hearing loss
__ Ringing in ears
__ Discharge from ear
__ Night blindness
__ Color blindness
__ Spots before eyes
__ Eye pain
__ Red eyes
__ Excessive tearing
__ Dry eyes
__ Nasal Discharge
__ Sinus infection
__ Nosebleeds

__ Vivid dreams
__ Nightmares
__ Drowsiness
__ Wake up easily
__ Not waking rested
__ Sleep Apnea
__ Other: _____

Respiratory
__ Asthma/ wheezing
__ Shortness of breath
__ Pain with breathing
__ Shallow breathing
__ Recurrent/ chronic cough
__ Production of phlegm
__ Coughing up blood
__ Bronchitis
__ Emphysema
__ Pneumonia

Cardiovascular
__ High Blood Pressure
__ Low Blood Pressure
__ Chest pain or tightness
__ Palpitations
__ Irregular heartbeat
__ Cold hands or feet
__ Easy bleeding or bruising
__ Blood clots
__ Spider veins
__ Fainting

Genito-urinary
__ Painful/difficult urination
__ Frequent urination
__ Urgent urination
__ Bleeding
__ Nocturnal urination- # times ____
__ Cloudy
__ Change in urinary flow
__ Urinary incontinence
__ Nocturnal incontinence
__ Dribbling urination
__ Recurrent bladder infections
__ Low libido
__ Kidney stones
__ Prostate problems
__ Impotence
__ Rashes/itching
__ Recurrent herpes or HPV outbreaks

Neurological/ Mental
__ Seizures
__ Tremors
__ Paralysis
__ Stroke
__ Concussion
__ Nerve Damage
__ Peripheral Neuropathy
__ Loss of balance
__ Lack of coordination

__ Hay Fever
__ Gum/lip/mouth sore
__ TMJ
__ Bleeding gums
__ Teeth grinding
__ Sore throat
__ Hoarseness/ voice loss

Gastrointestinal
__ Little appetite
__ Excessive appetite
__ Stomach Acid/Reflux
__ Gas/bloating
__ Stomach or Abdominal Pain
__ Nausea
__ Diarrhea/loose stools
__ Constipation
__ Rectal bleeding/hemorrhoids
__ Bloody stools
__ Pale colored stools
__ Black-tarry stools
__ Pain with passing stools
__ Gas/ flatulence
__ Gallbladder problems/ stones
__ Appendicitis
__ Hernia
__ Bad breath

Musculoskeletal
__ Shoulder pain
__ Neck pain
__ Upper back pain
__ Low back pain
__ Hand/ wrist pain
__ Knee pain
__ Foot/ ankle pain
__ Joint/ bone problems
__ Muscle wasting/ weakness
__ Osteopenia/ osteoporosis
__ Herniated disc
__ Sciatica
__ Other : _____

Psychological/ Behavioral
__ Depression
__ Fearfulness
__ Anxiety
__ Panic attacks
__ Often stressed
__ Easily angered
__ Aggressive behavior
__ Lose control of emotions

Women's Health Questionnaire

Date of last menstrual period _____ At what age did you start menstruating? _____
What is the length of your cycle (ex: 28-30 days) _____ How many days do you bleed?_____
How would you describe your flow:
Light __ Medium __ Heavy__ Irregular __
What color is the blood?
Bright red __ Dark red __ Pale red __ Purplish __ Brownish__

Are there any clots? _____ Color _____ Symptoms before your period (PMS):
_____
Symptoms during your period: _____
After your period: _____
How many times have you been pregnant? _____
Deliveries _____ Cesareans _____ Abortions _____ Miscarriages_____
Did you experience complications with pregnancy and/or delivery?
_____

Fertility Enhancement

How long have you been trying to conceive? _____

Is there a diagnosis causing the reproductive challenge? _____

If so, subsequent treatments to address the cause (fibroids, cysts, hormonal imbalance…)?
_____

Have you undergone Western medical procedures (IVF, IUI…etc)? Please specify cycles, medications, and treatments. _____
_____

Gynecological Conditions

__ Irregular menstruation
__ Painful menstruation
__ Premenstrual symptoms
__ Menopausal symptoms
__ Abnormal PAP smear
__ Nipple discharge
__ Breast Lumps
__ Breast Cancer/Tumor
__ Pain with intercourse
___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal itching/dryness

Please explain any conditions checked above _____
_____
_____

Other comments or helpful information you would like Dr. Di Giulio and Dr. Munson to be aware of:

Thank You ~
Acupuncture & Oriental Medicine of Napa Valley