Original Date:
Dates Revised:

QI HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:** **Age:**
DL#	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Address *(Street & Apt # if applicable):*	**Contact Number:**
Address Cont. *(City, State, Zip)*	☐ Mobil ☐ Work ☐ Home
Emergency Contact Name:	**Emergency Number:**
	☐ Mobil ☐ Work ☐ Home
Email ***(Office Use Only):***	
Previous or referring doctor:	**Date of last physical exam:**
How did you hear about our office?	
Special Hobbies or Activities:	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
Check most frequent childhood issues: ☐ Colds ☐ Ear Ache ☐ Sore Throat ☐ Digestive Problems		
Diagnosed medical problems: ☐ Heart Disease ☐ Asthma ☐ Cancer ☐ Diabetes I/II ☐ Seizures ☐ High Blood Pressure ☐ Emphysema ☐ Depression		
Conditions not listed above:		
Infectious Diseases: ☐ Hepatitis ☐ HIV/AIDS ☐ TB ☐ STD (type): ☐Other		

Hospitalizations or Surgeries *(w/scar location)*

Year	Reason	Hospital

Accidents or Injuries *(include car, sports injuries, etc)*

Year	Reason	Hospital (if applicable)

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as inhalers, vitamins, and herbs. *It has become common practice for many doctors to prescribe medications for conditions other than the medication was originally designed. Completing the second column will save time and avoid misinterpretation of your prescription intent.*		
Drug Name	Purpose	Strength & Frequency Taken

Allergies to medications, food substances, or pollen *(indicate which type and season most aggravated)*	
Drug Name/Food Substance/Pollen	Reaction

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Exercise	☐ Sedentary *(No exercise)*		
	☐ Mild exercise *(i.e., climb stairs, walk 3 blocks, golf)*		
	☐ Occasional vigorous exercise *(i.e., work or recreation, less than 4x/week for 30 minutes)*		
	☐ Regular vigorous exercise *(i.e., work or recreation 4x/week for 30 minutes)*		
	What kind of exercise do you do?		
	What kind of exercise do you enjoy/prefer?		
Energy	How would you rate your energy on a scale of 1-10? Do you feel tired all the time? How long has fatigue been a problem?	☐ Yes	☐ No
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	Is your weight stable? ☐ Yes ☐ No Are you happy with your weight? ☐ Yes ☐ No		
	How would you characterize your diet? ☐ All American ☐Chicken & Fish Only ☐Vegetarian ☐Other:		
	How is your appetite?		
	What taste(s) do you crave? ☐Sweet ☐Salty ☐Sour ☐Spicy ☐Pungent ☐Other		
	# of meals you eat in an average day : Number of snacks in an average day: Type:		
	Servings of red meat in an average day: Servings of foul per week:		
	Servings of fish in an average week: Servings of vegetables in an average day:		
	Servings of processed meat a day *(i.e. lunchmeat, sausage, hot dogs, Mc Nuggets, etc.)* :		
	Servings of fruit in an average day *(Please do not include pies or cobblers in this section)*:		
	Servings of fried foods in the past week *(include fried meats, vegetables, fruits, & pies):*		

Diet	Rank salt intake	☐ Hi	☐ Med	☐ Low (1500-2400mg:1tsp =approx. 2000mg)		
	Rank fat intake	☐ Hi	☐ Med	☐ Low (25-35% total calories)		
Beverage	Are you often thirsty?	☐Yes ☐No	☐ For Hot drinks	☐ For Cold drinks		
H²O	Glasses of Water Daily		Water Type	☐ Tap ☐ Filtered ☐ Bottled ☐ Spring ☐ Distilled		
Caffeine	☐None	☐ Coffee	☐ Tea: ☐ B ☐G ☐H	☐ Cola		
	# of cups/cans per day? If you drink caffeine free soda, how many cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Quit-# of year				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
	Have you ever or are you currently addicted to street drugs or prescription medication?				☐ Yes	☐ No
	Have you every enrolled in a treatment program or sought counseling for an addiction?				☐ Yes	☐ No
	Would you like information on addiction treatment, counseling or drug detox treatment programs				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Do you have more than one sexual partner?				☐ Yes	☐ No
	Any discomfort with intercourse?				☐ Yes	☐ No
	Are you happy with your libido (sexual desire level)?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	

Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

What emotion do you thinks is most characteristic of you?	☐Joy	☐Grief	☐Fear	☐Anger	☐Worry
What emotion do you think others believe most characteristic of you?	☐Joy	☐Grief	☐Fear	☐Anger	☐Worry
Which emotion do you think you hold in or suppress?	☐Joy	☐Grief	☐Fear	☐Anger	☐Worry

Is stress a major problem for you? Describe:	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently or experience uncontrollable crying?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping? If yes, mark all that apply	☐ Yes	☐ No
☐Hard to fall asleep ☐Easy waking, hard to get back asleep ☐Awake too early	☐ Yes	☐ No
☐Awake tired in morning ☐Restless dreaming ☐Nightmares	☐ Yes	☐ No
Additional Info:	☐ Yes	☐ No
Are you obsessive in work or relationships?	☐ Yes	☐ No
Do you have any feelings of claustrophobia?	☐ Yes	☐ No
Physical and/or mental abuse has also become a major public health issues in this country. This abuse often takes the form of verbally threatening behavior or actual physical or sexual abuse. Have you ever been a victim of sexual, physical or mental abuse as a child or an adult? If so, indicate type:	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Counseling services are available at Phoenix Professional Practice Associates. Would you like an inter-office referral?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation: Age at Menopause:

Period every days or Irregular with *(mark all that apply)* ☐ Spotting ☐ Discharge ☐ Pain

Date of last menstruation: Length of menstruation:

Any Premenstrual Discomfort? ☐ Yes ☐ No

Number of Days: Describe problem and severity *(i.e. bloating, irritability, etc.)*:

How would you characterize your menstruation: *(mark all that apply)*

Flow: ☐Heavy ☐Medium ☐Light *Color:* ☐Bright Red ☐Dark Red ☐Brown

Cramps: ☐None ☐Mild ☐Severe ☐At start ☐At End *Clots:* ☐At start ☐At End ☐Middle ☐Heavy ☐Medium

(B)Better or (W)Worse with Heat Cold Pressure

Additional Details if Needed:		
Number of pregnancies: Number of live births: Number of miscarriages: Number of abortions: Complications of pregnancy/childbirth:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean? If so, indicate procedure:	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or night sweats?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Any unusual vaginal discharge? Describe if any:	☐ Yes	☐ No
Date of last pap and mammogram?		

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Date of last prostate and rectal exam:		
Date of last testicular exam:		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with obtaining or maintaining erection, or premature ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort
☐ Lungs	☐ Circulation	

Additional Information Regarding Any of the Above or Any Issue Not Previously Addressed:

HISTORY OF PRESENT ILLNESS

What health concern would you like treated today?

In the space provided, please indicate when the complaint initially began and any precipitating factors involved *(Please describe as fully as possible):*

What treatment have you been using for relief of this problem?

Have you noticed if the condition is (B)Better or (W)Worse with ____________ Heat ______________ Cold____________ Pressure

(B)Better or (W)Worse during certain times of the year: _______Fall _______Winter _______Spring _______Summer

Have you had an Acupuncture treatment before? ☐Yes ☐No If Yes, when and for what condition?

If the Concern is Musculoskeletal, Please See Below:

(Mark ALL That Apply)

General Pains:

☐Headaches *(describe including location of pain)*:

☐Muscle Weakness ☐Muscle Twitching ☐Spasms ☐Muscle Pain

☐Pain in Ribs ☐Pain in Stomach ☐Pain in Lower Abdomen ☐Pain in Chest

☐Heartburn ☐Lump in Throat ☐Sour Taste in Mouth

☐Backache:

☐Upper ☐Middle ☐Lower

☐Dull ☐Sharp ☐Radiates: Where ____

☐Neck Pain *(describe)*: ____

☐Joint Pain *(location)*: ____

☐Inflamed ☐Red ☐Cold ☐Stiff ☐Fused or enlarged joints

How would you characterize your pain:

☐Sharp ☐ Dull ☐Constant ☐Occasional

☐Fixed location ☐Moves around

What makes the back, neck or joint pain change?

☐Damp ☐Dry ☐Heat ☐Cold ☐Wind ☐Rest ☐Activity ☐Eating ☐Summer ☐Winter

☐Other __________________________

(B)Better or (W)Worse with ___________ Heat ______________ Cold________________ Pressure Other:

Temperature:

Do you feel: ☐ More Hot ☐ More Cold ☐ Cold Hands ☐ Cold Feet ☐ Cold Nose

Eyes:

☐Red ☐Irritated ☐Floating Spots ☐Blurred Vision ☐Double Vision ☐Night Blindness

Irritability:

☐Rarely ☐Occasionally ☐Often

Ears:

☐Hearing Loss : Severity and Cause ☐Ringing in ears: Pitch

Teeth and Gums:

☐TMJ Problems ☐Grinding Teeth ☐Clicking Jaw

Describe Problems:

Digestion:

☐Good

☐Discomfort **Before** or **After** Eating Location :

☐Belching or Burping ☐ Mild ☐ Moderate ☐ Severe

☐Heartburn ☐ Mild ☐ Moderate ☐ Severe

☐Gas: ☐ Mild ☐ Moderate ☐ Severe

Bowel Movements

☐ Constipation ☐ Hard ☐ Pellets ☐ Blood ☐ Tar Black

☐ Soft ☐ Diarrhea ☐ Watery ☐Explosive

☐ Rotating constipation and diarrhea ☐ Affected by stress

Bowel Movements frequency *(please indicate number per day or week)?*

Urination:

☐ Dark ☐ Cloudy ☐ Painful ☐ Burning ☐ Blood tinged ☐ Pale ☐ Copious

☐ Difficulty voiding(not empty) ☐ No control ☐ Stress incontinence ☐ Difficulty starting ☐ Enuresis ☐ Dribbling

☐ Frequent bladder infection

Other:

☐ Tend to Bruise Easily ☐ Hemorrhoids ☐ Varicose veins ☐ Prolapsed organs: Where

☐ Edema: Where When

Do you experience any of the following:

☐Daydreaming ☐Lack of concentration ☐Difficulty making decisions ☐Inability to think clearly ☐Forgetfulness

☐Lightheadedness ☐Fainting ☐Palpitations ☐Irregular heartbeat ☐Angina

☐Dizziness ☐Vertigo ☐ Low blood pressure

Traditional Chinese Medicine is a system that views the person as a whole. It may not be apparent to you how some of these questions are related to your health problem, but your answers will provide a framework for understand your overall health and improve patient outcomes

Office use Only

RVH Notes:

Follow Up Questions: