CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

COMPASSIONATE ACUPUNCTURE AND HEALING ARTS
Barbara Connor, M.Ac., L.Ac. and John G. Connor, M.Ac., L.Ac.
4501 Valley Forge Road, Durham, NC27705
Phone (919) 309-7753 Fax (919) 309-7753

Date:_____

Name:_____ Phone: (Home)_____

Phone (Work)_____ Phone: (Cell)_____

Address:_____ City:_____

State_____Zip_____ E-mail:_____

Age:_____ Date of birth_____ Occupation.:_____

Employer's name:_____

Full time:___ Part time: ___ School: ___ Retired: ___ Unemployed: ___ Other: ___

Support activities/pursuits/groups: _____

Living Situation: Alone: ___ Friends: ___ Spouse: ___ Partner: ___ Parents: ___ Children: ___

Name of Partner/Spouse: _____

In emergency notify: _____ Phone: _____

Referred by: _____

Main health issues you would like to address at this time :

_____

_____

CANCER INFORMATION (**This section to be filled out by cancer patients only**.)

Have you ever been diagnosed with cancer, a mass or a tumor? Yes: __No: __When: ___

Location: _____ Type: _____

Current status (eg. post surgery, recurrence, etc.): _____

Current Stage: _____ Relevant Tumor Markers: _____

CONVENTIONAL CANCER TREATMENT HISTORY

Date Surgery Chemotherapy Radiation Dose Duration

_____

_____

_____

If you are in a clinical trial or experimental protocol please provide details:

_____

CURRENT/RECENT HEALTH CARE PROVIDERS (Surgery, Oncology, Primary Care)

Name Dates Care Provided

_____

_____

_____

FAMILY HISTORY

Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, other addiction or illness.

Member Still Living Age Diseases Causes of death Age at Death

Mother_____

Father_____

Siblings_____

Siblings_____

Maternal Grandmother_____

Maternal Grandfather _____

Paternal Grandmother_____

Paternal Grandfather_____

PERSONAL HISTORY

Please check if you have had or have at present any of the following:

Allergies ____	Asthma _____	Arteriosclerosis____
Arthritis _____	Artificial Joints_____	Crohn's _____
Chronic Cough _____	Chronic Diarrhea _____	Colitis _____
Diabetes_____	Diverticulitis _____	Hepatitis A _____
Hepatitis B ____	Hepatitis C _____	HIV/AIDS_____
Kidney Stones____	Liver Disease___	Lupus _____
Lyme Disease____	Mononucleosis ____	Pacemaker ___
Parasites _____	Seizures /Epilepsy___	Stroke____
Thyroid Disease___	Ulcer _____	Venereal Disease ____

Have you been treated by acupuncture or Oriental medicine before? _____

HOSPITALIZATIONS / SURGERY (NON CANCER)

Date Hospital Diagnosis/Operation Doctor

_____

_____

_____

_____

ACCIDENTS / INJURIES Briefly Describe:

More than 5 years ago _____

Less than 5 years ago_____

Height_____Weight_____Blood pressure: _____ Skin: Dry ___ Oily ___Normal___

Birth history (prolonged labor, forceps delivery, etc): _____

Please rate the following on a scale of 1 to 10 (10 being the best) - write any comments

Sleep_____ Energy Level _____

Appetite _____ Digestion _____

Do you rely on any of the following for bowel elimination? (Yes or No) Enemas _____

Laxatives _____ Purgatives _____ What type or brand? _____

Name & Brand of Current Supplements or Herbs Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Medication What it is for? Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

Medications or herbs you have allergies to:

_____

Occupational stress (chemical, physical, psychological, etc.):

_____

Have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life?

___m_____

Do you have a regular exercise program? Yes ____ No ____ What kind?

_____

Have you been or are you on a restricted diet? Yes____ No ___ What kind?

_____

Please describe your average daily diet:

Breakfast:

_____

_____

Lunch:

_____

_____

Dinner:

_____

_____

How many cigarettes do you smoke per day? _____

How much coffee, tea or cola do you drink per day? (Specify) _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical or recreational purposes:

_____

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST YEAR

GENERAL

__ Chills __ Fevers __ Sweat easily
__ Night sweats __ Localized weakness __ Bleed or bruise easily
__ Peculiar taste or smells __ Strong thirst (cold or hot) __ Thirst, no desire to drink
__ Fatigue __ Sudden drop in energy - *At what time of day?* _____
__ Edema __ Poor sleep __ Tremors
__ Cravings __ Change in appetite __ Weight gain
__ Weight loss Other_____

SKIN & HAIR

___Rashes __ Itching __ Change in hair or skin
__ Ulcerations __ Eczema __ Oozing from skin lesion
__ Hives __ Pimples __ Recent moles
__ Loss of hair __ Dry skin ___ Cracked Nails
Other: _____

HEAD, EYES, EARS, NOSE AND THROAT

__ Dizziness __ Facial pain __ Migraines
__ Headaches *When?* _____ *Where?* _____
__ Poor vision __ Blurry vision __ Color blindness

__ Blind field __ Spots in front of eyes __ Eye pain
__ Eye strain __ Cataracts __ Eye dryness
__ Excessive tears __ Discharge from eyes __ Poor hearing
__ Ringing in ears __ Earaches __ Discharge from ear
__ Nose bleeds __ Sinus congestion __ Teeth grinding
__ Teeth problems __ Concussion(s) __ Recurrent sore throats
__ Hoarseness __ Sores on lips or tongue Other: _____

CARDIOVASCULAR:

__ High blood pressure __ Low blood pressure __ Chest discomfort/pain
__ Heart palpitations __ Cold hands or feet __ Swelling of hands
__ Swelling of feet __ Blood clots __ Fainting
__ Difficulty breathing Other cardiovascular problems: _____

RESPIRATORY:

__ Cough __ Asthma/wheezing __ Pain with a deep breath
__ Difficulty in breathing when lying down __ Coughing blood
__ Production of phlegm *What color?* _____ __ Bronchitis
__ Pneumonia Other lung problems: _____

GASTROINTESTINAL:

__ Nausea __ Vomiting __ Heartburn
__ Belching __ Indigestion __ Diarrhea
__ Constipation __ Chronic laxative use __ Blood in the stools
__ Abdominal pain/cramps __ Gas __ Rectal pain
__ Hemorrhoids Other stomach or intestinal problems: _____

UROGENITAL:

__ Pain on urination __ Urgency to urinate __ Frequent urination
__ Blood in the urine __ Decrease in flow __ Unable to hold urine
__ Dribbling urine __ Impotency __ Change of sexual desire
__ Sores on genitals __ Night-time urination *How often?* _____
Color of urine: _____ Other urogenital problems: _____

GYNECOLOGY AND PREGNANCY:

Number of pregnancies __ Number of births __ Premature births __
Miscarriages __ Abortions __ Age at first menses _____
Days between menses __ Length of periods __ First date of last menses __
__ Unusual character (light or heavy) __ Painful periods
__ Irregular periods __ Changes in body/psyche prior to menstruation
__ Clots __ Menopause at age __ __ Vaginal discharge
__ Vaginal sores Last Pap _____ __ Breast lumps
__ Practice birth control *What type and for how long?*_____

__ PMS symptoms Please describe: _____

NEUROPSYCHOLOGICAL:

__ Seizures __ Area of numbness: *Where?* _____
__ Weakness __ Sleep disorder __ Poor memory
__ Bad temper __ Loss of control/violence potential
__ Depression __ Anxiety __ Easily susceptible to stress
__ Vertigo __ Loss of balance __ Lack of coordination
__ Muzzy headedness/lack of clarity __ Substance abuse
Have you every been treated for emotional problems? Yes __ No __
Have you ever considered or attempted suicide? Yes __ No __
Other neurological or psychological problems: _____

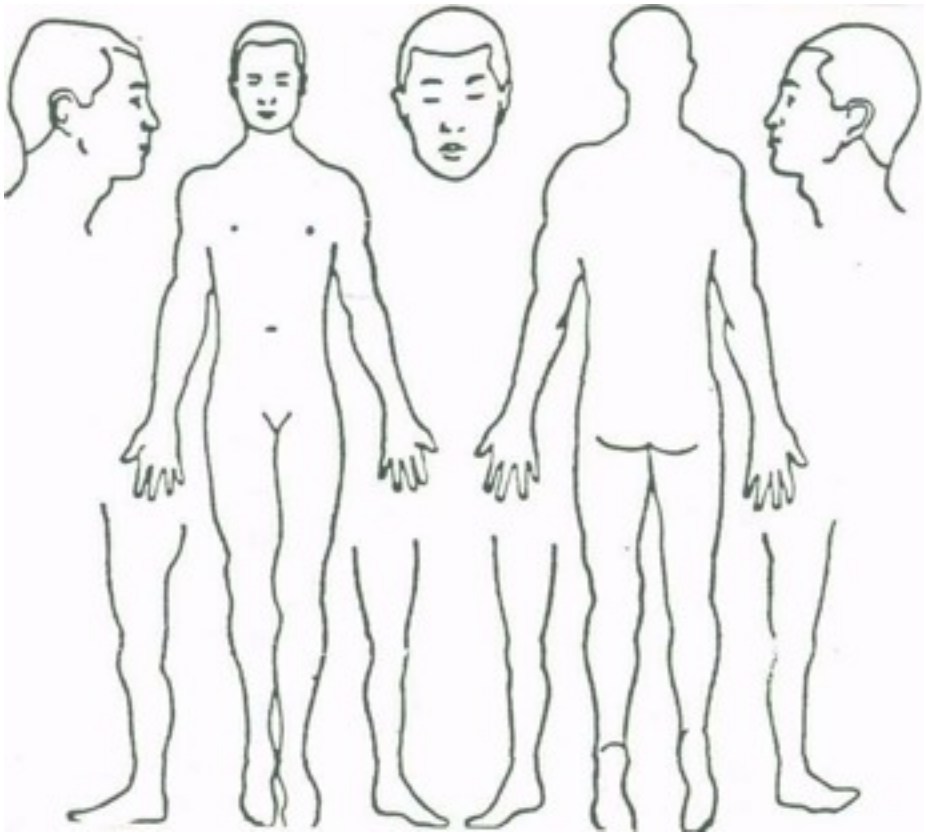
MUSCULOSKELETAL:

__ Neck pain __ Shoulder pain __ Back pain
__ Elbow pain __ Hand/wrist pain __ Hip pain
__ Knee pain __ Foot/ankle pain __ Muscle pains
__ Muscle weakness __ Heaviness in the limbs
Other musculoskeletal problems: _____

Refer to the drawing below and please indicate painful or distressed areas on it_____

How would you rate your pain levels on a scale of 0 - 10 (10 being worst pain level)_____

How would you rate the frequency of the pain in these areas _____



Please note: You will be charged the full fee for missed appointments without 24 hours advance notice.

Free Daily Email Health Newsletter. ____ Yes, I would like to receive this.

____ No, I prefer not to receive this.