COMPREHENSIVE HEALTH HISTORY

Medical History

Reason for seeking acupuncture treatment: _____

Medication allergies and reactions: _____

Have you had any major accidental injuries or broken bones: _____

Do you have heart problems? Yes No

Do you wear a cardiac pacemaker? Yes No

Are you pregnant (female patients)? Yes No

Have you had?	No	Yes	Date	Have you had?	No	Yes	Date
Arthritis				Kidney Disease			
Asthma				Lung disease			
Bladder infection				Surgery			
Cancer				Syphilis			
Diabetes				Thyroid problems			
Herpes				Tuberculosis			
High blood pressure/Stroke				Ulcers			

Medications	Dosage

Social History

Education – Circle Highest level		Occupation	
Grade School	College School	Are you exposed to stress at work?	Yes or No
High School	Postgraduate	Physical Strain?	Yes or No
		Hazardous Substances	Yes or No

How many servings of each per day?		How often do you?				
Fruits	Milk/Dairy	Drink Alcohol	day	week	month	year
Vegetables	Nuts/Beans	Take Drugs	day	week	month	year
Breads/Cereals	Snacks	Smoke	day	week	month	year
Eggs/Meat	Caffeine	Exercise: type?	day	week	month	year