The Center for Traditional Acupuncture and Herbs
591 State Rte 244, Alfred Station, NY 14803
Kevin Ferst, LAc. & Sarah Nelson Ferst, LAc.

Confidential Patient Health History Questionnaire

Today's date M______D_______Y_______

Name____ Nickname_________________________________

Phone (H) _____________________ (W)_________________________ (C)___________________________________

Address ____

City ___________________ State ________ Zip ________________E-mail __________________________________

Age _________ Date of Birth M_______D________Y________Place of Birth______________________________

Height ___________ Weight ___________ Marital/Partnership Status ____________________________________

Profession/Occupation____________________________________

Family Physician __________________________________ Referred By ____________________________________

Emergency Contact _______________________________________ Phone_________________________________

Have You Been Treated By Acupuncture or Oriental Medicine Before? Yes No

Main Problem(s) you would like help with ____

____

How long ago did this problem begin (be specific)? ____

____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? ____________________

____

Have you been given a diagnosis for this problem: If so, what? ____

____

What kinds of treatment have you tried? ____

____

Past Medical History (please include date): Cancer _________ Diabetes _________ Hepatitis __________
Blood Pressure High/Low _____/_____ Heart Disease _____________ Rheumatic Fever__________________
Thyroid Disease ___________Seizures ___________ STDs__________________ HIV/AIDS ___________________
Other ____

Surgeries (type of and date)____

____

Significant Trauma (auto accidents, falls, etc) ____

____

Significant Dental Work (type and date)____

Allergies (drugs, chemicals, foods/result) ____

Family Medical History (check): Diabetes Cancer High Blood Pressure
Heart Disease Stroke Seizures Asthma Allergies
Other ____

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________

Occupational Stress (physical, chemical, psychological, etc) ____
____

Do you have a **regular exercise program**? Yes No Please Describe ____________________
____

Have you ever been on a **restricted diet**? Yes No What Kind? _______________________
____

Are you a smoker? Yes No Quit

If so, how many **packs of cigarettes** do you smoke per day? _____/day

How many caffeinated beverages (**coffee, cola**, **energy drinks**) do you drink per day? ___________________

How much **alcohol** do you drink per week? ____

Please describe any use of recreational drugs ____

Please check any problems you have had in the last three months:

General
- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- No desire to drink
- Sudden energy drop
  - When? ________________
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair
- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles

Skin and Hair (continued)
- Warts
- Other hair or skin problems

____

____

Musculoskeletal
- Muscle pain
- Muscle weakness
- Neck pain
- Shoulder pain
- Hand/wrist pain
- Back pain
- Hip pain
- Knee pain
- Foot/ankle pain

Cardiovascular
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Swelling of feet
- Phlebitis
- Chest pain
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____________ _____________________

Head, Eyes, Ears, Nose, and Throat
- Dizziness
- Poor vision
- Cataracts
- Eye strain
- Night blindness
- Blurry vision
- Spots in front of eyes
- Eye pain
- Color blindness
- Earaches
- Ringing in ears (tinnitus)
- Poor hearing
- Sinus problems
- Grinding teeth
- Teeth problems
- Jaw clicks
- Facial pain
- Nose bleeds
- Recurrent sore throats
- Sores on lips or tongue
- Concussions
- Migraines
- Headaches - where and when ________________ _____________________
- Other head or neck problems _____________ _____________________

Respiratory
Cough
Bronchitis
Pneumonia
Asthma
Tuberculosis
Pain with a deep breath
Difficulty in breathing when lying down
Production of phlegm what color ____________
Coughing blood
Other lung problems _____ ________________________
Approximately when was your last cold or flu?________ ________________________

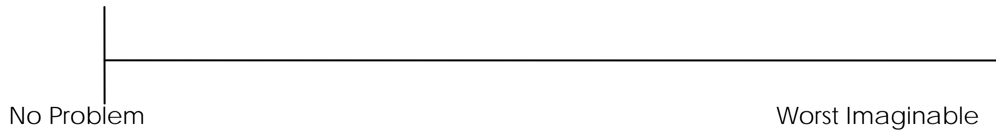
Gastrointestinal
Nausea
Constipation
Diarrhea
Chronic laxative use
Bad breath
Belching
Burning sensation
Abdominal pain or cramps
Vomiting
Gas
Indigestion
Blood in stools
Black stools
Rectal pain
Rectal burning
Anal Prolapse
Hemorrhoids
Other stomach or intestinal problems ______________ ______________________

Pregnancy and Gynecology
Number of pregnancies ____
Number of births _________
Premature births _________
Miscarriages _____________
Abortions _______________
Age at first menses _______
Days between menses _____
Duration ________________
First day of last menses ____ _______________________
Unusual character (heavy or light)
Painful periods
Vaginal discharge
What color?___________
Changes in body/psyche prior to menstruation
Clots
Vaginal sores
Irregular periods
Last Pap _____________
Breast lumps
Fibroid Cysts
Are you sexually active?__
Do you practice birth control?
Yes No N/A
What type and for how long? _______________________
Other Gynecology related concerns________________ _______________________ _______________________

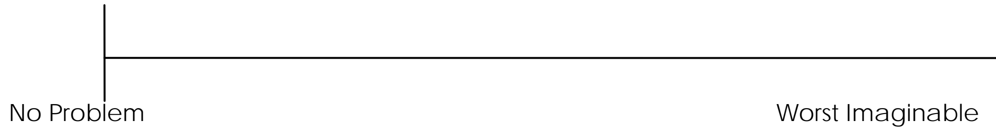
Genito-urinary
Pain on urination
Urgency to urinate
Frequent urination
Unable to hold urine
Urinary difficulty
Impotency
Blood in urine
Kidney stones
Sores on genitals
Other genital or urinary system problems ________ _______________________
Do you wake up to urinate?
Yes No
How often? _______________
Any particular color to your urine? _______________

Neuropsychological
Seizures
Stroke
Tremors
Fainting spells
Areas of numbness
Concussion
Poor memory
Dizziness
Vertigo
Loss of balance
Lack of coordination
Depression
Easily stressed
Bad temper
Anxiety
Difficulty concentrating
Other neurological or psychological concerns
____
____

Please note the severity of your main problem now:



Please note the severity of your main problem within the last week:



Comments (please mention any other problems or concerns you would like to discuss)

____

____

____

Indicate painful or distressed areas