KIMIA WELLNESS
Acupuncture & Herbal Medicine

Medical History Questionnaire

Please help us understand your past and present medical history.

Name: _____ DOB:_____
Address: _____
Phone: _____ Email:_____
Emergency Contact: _____ Phone:_____ Relationship:_____

Primary Concern:_____
When did this first begin? _____ Is it constant? ___ Yes ___ No
Aggravating and Relieving Factors: _____

Secondary Concern: _____
When did this first begin? _____ Is it constant? ___ Yes ___ No
Aggravating and Relieving Factors: _____

Please list any other concerns and reasons for your visit:_____
_____

Tell Us About Your Past Medical History:

Please check if you have experienced the following conditions.

__Asthma	__Anemia	__Appendicitis	__Arteriosclerosis	__Arthritis	__Bronchitis
__Cancer	__Colitis	__Chronic Fatigue	__Depression	__Diabetes	__Epilepsy
__Emphysema	__Eating Disorder		__Fibromyalgia	__Gout	__Gallstones
__Goiter	__Hepatitis C	__Heart Disease	__Hepatitis	__HIV	__Hypertension
__Hyperthyroid	__Hypothyroid	__High Cholesterol	__Low Blood Pressure	__Mono	__Meningitis
__Paralysis	__Pacemaker	__Mumps	__Pneumonia	__Polio	__PTSD
__Kidney Stones	__Rheumatic Fever	__Reynaud's	__Stroke	__TB	__Ulcers

Allergies: _____
Addictions: _____
Cancer? What Type? _____
Hospitalizations, Surgeries, Major Injuries/Illnesses:_____
_____

Your Family's Medical History:

Please list family members who have had any of the following.

Addictions _____ Asthma _____ Cancer _____
Diabetes _____ Hypertension _____ Heart Disease _____
Mental Illness _____ Stroke _____ Thyroid Disease _____

Tell Us About Your Lifestyle:

Diet: _____ Exercise:_____
Recreational Drugs: ___ Yes ___ No Smoking: _____Cigarettes per day / week
Alcohol: _____drinks per day / week Caffeine: _____cups per day / week
Sleep: Average hours of sleep per night: _____ Average time you go to bed: _____
How long does it take you to fall asleep? _____ Times you wake at night: _____
Do you feel rested when you wake up? ___Yes ___No Overall Energy Level: _____/10

Current State of Health:

My body temperature feels? ___Hot ___Moderate ___Cold Current Energy Level: _____/10

Please check any that apply to you:

General Symptoms

__Edema	__Bruise Easily	__Chills/Fever	__Strong Thirst	__Low Thirst
__Aversion to Wind	__Aversion to Cold	__Aversion to Heat	__Poor Appetite	__Night Sweats
__Insomnia	__Fatigue	__Nasal Congestion	__Foggy Headed	__ Body Aches

Head/Ears/Eyes/Nose/Throat

__Dry Eyes __Red Eyes __Blurry Vision __Poor Night Vision __Floaters __Eye Strain
__Cataracts __Glaucoma __Glasses/Contacts __Ear Ringing __Poor Hearing __Ear Aches
__Blocked Sinuses __Nose Bleeds __Grinding Teeth __Dental Problems __Hoarseness __Mouth Sores
__Headaches __Concussion __Migraines __TMJ __Facial Pain __Sore Throat
__Bell's Palsy __Feeling of Lump in Throat __Goiter

Cardiovascular Symptoms

__High Blood Pressure __Low Blood Pressure __Irregular Heartbeat __Heart Palpitations __Heart Murmur
__Cold Hands/Feet __Phlebitis __Chest Pain __Fainting __Left Arm Pain
__Varicose Veins __Swelling of Hands/Feet

Respiratory Symptoms

__Dry Cough __Wet Cough __Bronchitis __Phlegm __Pneumonia
__Asthma __Pain w/deep breath __Chest Tightness __Post-nasal drip __Labored Breathing
__Short of Breath __Emphysema __COPD

Gastrointestinal Symptoms

__Nausea __Constipation __Diarrhea __Gas __Abdominal Pain
__Hiccups __Acid Regurgitation __Belching __Indigestion __Bad Breath
__Rectal Pain __Anal Fissures __Itchy Anus __Hemorrhoids __Bloating

Genitourinary

__Frequent Urination __Waking Up to Urinate __Pain During Urination __Incomplete Urination
__Decreased Flow __Decreased Stream Power __Unable to Hold Urine __Bedwetting
__UTI __STDs __Foul Smelling Urine __Kidney Stones __Genital Sores/Itching

Men's Health

__Wet Dreams __Impotence __Enlarged Prostate __Premature Ejaculation __Low Libido
__High Libido __Low Semen Motility __Low Semen Volume

Gynecology and Obstetrics

__Irregular Menses __No Menses __Menstrual Clots __Heavy Menses __Endometriosis
__Ovarian Cysts __Uterine Fibroids __Pain before menses __Pain During Menses __Pain After Menses
__Vaginal Sores __Yeast Infections __Menopause __Low Libido __High Libido
__Vaginal Discharge __PID __PCOS __PMS

Currently Pregnant? _____weeks Live Births _____ Still Births _____ Abortions _____ Miscarriages _____
Date of Last PAP Smear: _____ Age Menses Started: _____ Birth Control? __Yes __No Type:_____
First Day of Last Menstrual Period: _____ Duration: _____
Color of Menstrual Blood: Pale/Bright Red/Red/Dark Red/Purple/Brown Flow: Spotting/Light/Moderate/Heavy

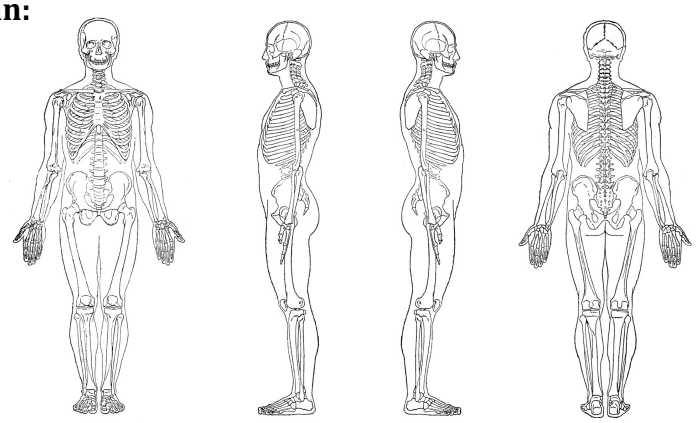
Neuropsychological

__Dizziness __Loss of Balance __Lack of Coordination __Tremors __Memory Loss
__Panic Attacks __Depression __Anxiety __Fearfulness __Nightmares
__Mania __Grief/Sadness __Anger/Irritability __Excessive Worry __Suicidal

Musculoskeletal

__Muscle Pain __Joint Pain __Muscle Atrophy __Muscle Weakness __Paralysis __Numbness/Tingling

Please mark areas where you feel pain:



Please list medications, including dosage:

_____
_____
_____
_____
_____
_____
_____
_____