CHINESE MEDICINE HEALTH HISTORY QUESTIONNAIRE

Each being is unique. No two persons are ever created exactly the same. Therefore any attempt made to heal must be approached by treating each person individually according to his / her particular patterns of disharmony.

These questions are designed to help in obtaining a complete picture as possible. If you have any questions regarding how to answer or if for some reason you object to a particular question leave it for now and it can be discussed during the interview.

All information will remain strictly confidential and will be released only upon your written consent.

Dr Damin Wan BM MMed MBAcC MRCHM

CHINESE MEDICINE HEALTH HISTORY QUESTIONNAIRE

Medical History Record

Name _____ Phone: Home _____ Mobile_____
Address _____ Date of Birth _____ Age _____
_____ Height _____ Weight _____
_____ Occupation _____
Referred by _____or
How do you know the practice _____
Your email address_____

Your Main Complaints

Main problem(s) you would like to be helped with?_____
_____
How long ago did this problem begin (be specific)? _____
The problems can be helped by (eg. weather, diet, exercise, medicine etc.)
_____
can be worsened by (eg.stress) _____
To what extent does this interfere with your daily activities (work, sleep, etc.)_____
_____
Are you presently being treated by a medical doctor? _____
Have you been given a diagnosis for this problem--if yes, what?
_____
What kind of treatments have you tried? _____
_____
_____

Have you ever been treated with acupuncture and /or Chinese herbal medicine?_____

Your Present Health (please tick only if you have at present)

Energy: Excellent ____ Good ____ Average ____ Tired ____ Very tired _____
Skin: Normal ____ Dry ____ Flaky ____ Greasy ____ Bumpy ____ Other _____
Headache: No ____ Yes ____
If yes, where? Front ____ Temple ____ Back ____ Top ____
How often? ____ a day / week /month
How long does each last? ____ minutes / hours / days
What kind of pain it is? (dull ache, stabbing etc.) _____
Dizziness ____ Lack of coordination ____ Depressed ____ Mental fogginess ____
Sleep: Trouble falling asleep ____ Awakes at night ____ Wakes early in morning ___
Excessive dreams ____ Nightmares ____ Wakes without feeling refreshed____
Constant desire to sleep ____ How many hours do you sleep a night ? _____
Memory and concentration: Good ____Average ____ Poor ____
Hair and scalp: Dry ____ Brittle ____ Hair loss ____ Dry scalp ____ Itchy scalp ____
Scaly scalp ____ Dandruff ____ Other _____
Eye: Poor vision ____ Blurring vision ____ Dry eyes ____ Gritty eyes ____
Itchy eyes ____ Other _____
Ear: Poor hearing ____ Deafness ____ Tinnitus ____ Excessive wax ____ Wet _____
Nose: Running nose ____ Clear discharge ____ Yellow or brown discharge ____
Blocked nose ____ Post-nasal drip ____ Hayfever ____ Other_____

Mouth: Dry mouth ____ Thirsty ____ Bad taste in mouth ____ Ulcers in mouth_____
Sores in corner of mouth ____ Other _____
Throat: Ticklish ____ Sore throat ____ Regular sore throats ____ Blocked feeling ___

Internal:
Catch colds easily ____ Sweating on exertion ____ Profuse sweating ____
Asthma ____ Wheezing ____ Shortness of breath ____ Tight chest ____ Cough ___
Clear mucus ____ Yellow or brown mucus ____ Other lung complaint _____

Palpitation ____ Angina ____ Other heart complaint _____

Appetite: Excellent ____ Good ____ Poor ____
Heartburn ____ Acidity ____ Belching ____ Nausea ____ Vomiting ____
Abdominal pain ____ Bloating ____ Rumbling ____ Flatulence (gas) ____
Bleeding from rectum ____ Other digestive complaint _____

Bowel movements: How many times? __ a day / week. Large __ Medium __ Small _
Normal to pass ____ Dry ____ Constipation ____ Loose ____
Diarrhoea ____ Alternating diarrhoea and constipation ____
Feeling bowels do not empty completely ____ Bad smell ____
Mucus in stool ____ Blood in stool ____ Other _____
Urination: How many times a day (approx.)? ____ a night (after sleep)? ____
Colour: Normal ____ Dark ____ Pale ____
Volume: Normal ____ Long ____ Short ____ Interrupted ____
Urgent ____ Painful ____Urine feels hot ____ Strong smell ____Other ___

Chills and fever: Aversion to cold ____ Cold hands ____ Cold feet ____ Fever_____
Hot person ____ Feels hot in night ____ Sweating in night ____
Hot flush ____Feel hot in palms, soles and chest ____
Low grade temperature ____ Other _____
Pain: please list those areas of your body in which you experience pain
_____

Males Only: Urine stream weak or slow ____ Dribbling after urination ____
Can't hold urine ____ Discharge from penis ____ Nocturnal emission __
Premature ejaculation ____ Low sex drive ____ Impotence_____
Hernia ____ Other _____

Females only:
Age you first begin to menstruate ____ Date of your last menstrual period ____
How many days does your period last __ How many days in your monthly cycle___
Heavy bleeding ____ Scanty bleeding ____ Pale bleeding ____
Cramping or pain before / during /after period ____ Bleeding / spotting between ___
Vagina discharge ____ Yellow or white discharge _____ Vaginal itching ___
Pain during intercourse ____ Bleeding sometimes after intercourse _____
Low sex drive ____ Disinterest in sex ____ Breast tenderness ____ Infertility ____
Genital herpes ____ Genital burning ____ Other _____
Number of abortions ____ Number of children ____ Ages _____
Age of menopause ____

Medications you are currently taking (please list)

_____

_____

Your lifestyle

Diet: Time of day you eat: Breakfast _____ Lunch _____ Dinner _____

	No	Yes	Weekly
Vegetarian	_____	_____	How long _____
Meat	_____	_____	How much _____
Fowl	_____	_____	How much _____
Fish	_____	_____	How much _____
Dairy	_____	_____	How much _____
Eggs	_____	_____	How much _____

Please list any food or taste which you have a particular craving for or aversion to

_____

Smoking: No ____ Yes ____ (Cigarettes / Cigar / Pipe / Marijuana)

If yes, How often _____ a day /a week How long _____ years / months

Quit _____ How long _____ years /months

Drinking

	Daily consumption	Weekly consumption	How long	Quit	How long
Beer	_____	_____	_____	___	_____
Wine	_____	_____	_____	___	_____
Spirits	_____	_____	_____	___	_____
Coffee	_____	_____	_____	___	_____
Soft Drinks	_____	_____	_____	___	_____
Tea	_____	_____	_____	___	_____

Physical fitness (please describe your programme of physical fitness)

_____

_____

Hobbies (please list any hobbies or recreational interests)

_____

_____

Emotions (choose one or two emotions that seem to predominate in your life, eg worry, anger, happiness etc.)

_____

Your Previous Medical History

Please list any major illness, serious injuries or hospitalisations you have had

_____ Year _____

_____ Year _____

_____ Year _____

Your Family History

	Living?	Age	General Health	Age of Death	Cause of Death
Father	_____	___	_____	_____	_____
Mother	_____	___	_____	_____	_____

Please list the health problems your family members have or had

_____

_____

_____

Other

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (eg divorce, change of residence, injury, death in family, bankruptcy etc.)

Date	Event
_____	_____
_____	_____
_____	_____

Please provide any information about yourself or some condition that might not have been covered by the above questions.

Signature _____ Date _____