Women's Health History Questionnaire

Blue Root Acupuncture, LLC ***Confidential***

2730 Devine Street • Columbia, SC 29205 • 803-404-7575 • www.blueroothealth.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date: / /	First Name:	Last Name:	Middle Initial:

Gender – *Circle One:* F M	Date of Birth: / /	Age:	SS#:	Height:	Weight:

Street Address:	City:	State:	Zip:

Phone (Daytime) – *Circle one*: Home Work Mobile ( )	Phone (Nighttime) – *Circle one*: Home Work Mobile ( )

Preferred Way of Contact – *Circle One:* Home Work Cell Call Text Email * *By choosing "Text", you agree to allow Blue Root Staff to contact you from their personal phone.*	Place of Employment: _____	Occupation: _____

Email: _____	Emergency Contact: Name: _____ Phone: _(_____)_____ Relationship to Patient: _____
Marital Status: *Check one (x)* ☐ **S** ☐ **M** ☐ **D** ☐ **Other:** _____	

How did you hear about us? Current Patient / Friend: _____ Doctor / Insurance: _____ Advertisement / Social Media: _____ (*Google, Facebook, Pinterest, Twitter, Google+*)	Are you under the care of a physician now? ☐ Yes ☐ No Physician's Name: _____ Physician's Phone: _(_____)_____ Specialty of Physician: _____

Have you had Acupuncture before? ☐ Yes ☐ No Did you have a positive experience? ☐ Yes ☐ No	Have you had Chinese Herbal Medicine? ☐ Yes ☐ No
Have you received a diagnosis for your conditions(s)? ☐ Yes ☐ No If yes, for what? _____ _____	Other current therapies: _____ _____

Major Complaint(s) in order of importance to you:

	Severe	Moderate	Slight	
1.	☐	☐	☐	_____
2.	☐	☐	☐	_____
3.	☐	☐	☐	_____

When/How did this condition occur? Give dates if possible.

1. _____

2. _____

3. _____

How do these conditions impair your daily activities?

1. _____

2. _____

3. _____

Is it getting worse?

1. _____

2. _____

3. _____

What seems to make it better?

1. _____

2. _____

3. _____

What seems to make it worse?

1. _____

2. _____

3. _____

Treatment(s) you have received for this condition(s):

1. _____

2. _____

3. _____

What treatments helped the most?

1. _____

2. _____

3._____

FAMILY MEDICAL HISTORY

Check any of the following conditions any of your *family* members currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ **Allergies (List): _____** ☐ **Arteriosclerosis** ☐ **Asthma** ☐ **Alcoholism** ☐ **Cancer (Type: _____)**

_____ ☐ **Diabetes (Type: _____)** ☐ **Depression** ☐ **Emphysema** ☐ **High Blood Pressure**

☐ **Hepatitis (Type: _____)** ☐ **Heart Disease** ☐ **High Cholesterol** ☐ **Seizures**

☐ **Stroke** ☐ **Thyroid Disorders** ☐ **Other(s): _____**

YOUR MEDICAL HISTORY

Check any of the following conditions *you* currently have, or have had in the past..
Please also check if you feel any of the following are a significant part of your medical history.

☐ **AIDS/HIV**
☐ **ALLERGIES**
☐ **APPENDICITIS**
☐ **ARTERIOSCLEROSIS**
☐ **ASTHMA**
☐ **ALCOHOLISM**
☐ **BIRTH TRAUMA**
☐ **CANCER (Type: _____)**
☐ **CHICKEN POX**
☐ **DIABETES (Type: _____)**
☐ **EMPHYSEMA**
☐ **EPILEPSY**
☐ **GOITER**
☐ **GOUT**
☐ **HEART DISEASE**
☐ **HEPATITIS (Type: _____)**
☐ **HERPES (Type: _____)**
☐ **HIGH BLOOD PRESSURE**
☐ **MULTIPLE SCLEROSIS**
☐ **MEASLES**
☐ **MUMPS**
☐ **PACEMAKER (Date: / /)**
☐ **PLEURISY**
☐ **PNEUMONIA**
☐ **POLIO**
☐ **RHEUMATIC FEVER**
☐ **SCARLET FEVER**
☐ **SEIZURES**
☐ **STROKE**
☐ **SURGERY (List):**
_____
_____
_____
☐ **THYROID DISORDERS**
☐ **MAJOR TRAUMA (Car, Fall, etc.: _____)**
☐ **TUBERCULOSIS**
☐ **TYPHOID FEVER**
☐ **ULCERS**
☐ **VENEREAL DISEASE**
☐ **WHOOPING COUGH**
☐ **OTHER (Specify):**
_____

MEDICAL CONDITIONS Please list conditions & surgeries you have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food.	OCCUPATIONAL CONCERNS Check (x) if your work exposes you to the following:	DIET & EXERCISE Check (x) all that apply.
Year	Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional).	☐ Medications If so, which ones: _____ _____ _____ _____	☐ Stress ☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting	☐ Regular Exercise ☐ Low Fat Diet ☐ Low-Carb Diet ☐ Vegetarian
		☐ Seasonal Which Season(s): _____ _____ _____	☐ Others:	☐ Drink Coffee Cups/Day: _____ ☐ Soft Drinks/Fruit Juices Oz./Day: _____
		☐ Environmental: _____ _____ _____ _____		Appetite: ☐ Low ☐ High Protein Intake: ☐ Low ☐ High
		☐ Food: _____ _____ _____	Occupation:	☐ Artificial Sweeteners ☐ Sugar ☐ Salty Foods Thirst for water: # Glasses per day: _____

YOUR LIFESTYLE

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Drugs ☐ Stress ☐ Depression ☐ Over-Eating

DIET

Breakfast: _____

_____

Snack: _____

Lunch: _____

_____

Snack: _____

Dinner: _____

_____

DIRECTIONS

If you currently have ANY of the symptoms below, **CHECK & RATE** its severity:
1, 2, 3, 4, or 5 – (5 being the worst). Leave blank *ONLY* if not applicable.

LIVER / GALLBLADDER
_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension / Pain: Joints / Neck / Shoulder
_____ Poor Circulation
_____ Emotional Eater
_____ Bad Taste / Bitter Taste
_____ Bad Breath
_____ Do You Crave: Sour

HEART / SMALL INTESTINE
_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life
_____ Do You Crave: Bitter

LUNG / LARGE INTESTINE
_____ Dry Cough
_____ Cough with Sputum
_____ Bloody Cough
_____ Wheezing
_____ Nasal Discharge / Circle Color:
White – Yellow – Green – Clear
_____ Post Nasal Drip / Circle Color:
White – Yellow – Green – Clear
_____ Sinus Infection
_____ Itchy, Red, Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes
_____ Asthma / Allergies
_____ Grief / Sadness
_____ Shortness of Breath
_____ Low Resistance to Cold or Flu
_____ Sneezing
_____ Mild Fever That Comes & Goes
_____ Smoke Cigarettes
_____ Emphysema
_____ Bronchitis
_____ Black / Blood in Stools
_____ Constipation
_____ Diarrhea
_____ Alternating Constipation & Diarrhea
_____ IBS
_____ Colitis / Spastic Colon
_____ Do You Crave: Pungent

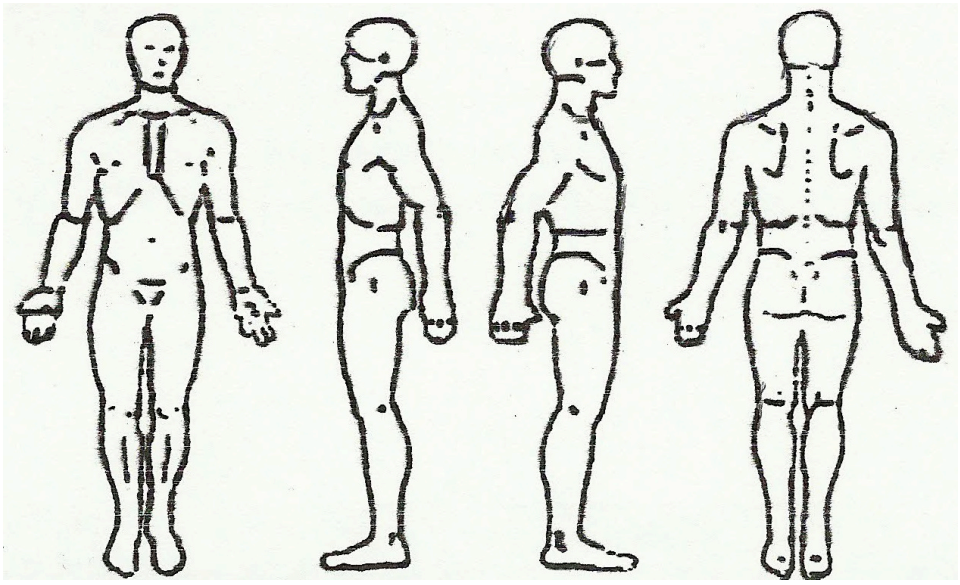
KIDNEY / URINARY BLADDER
_____ Decreased Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Cold Hands
_____ Cold Feet
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Weakness / Low Back Pain
_____ Hearing Problems
_____ Ringing in The Ears
_____ Cavities
_____ Fear
_____ Vaginal Discharge / Circle One:
White – Yellow – Green – Clear
_____ Hot Flashes / Night Sweating
_____ Urinary Problems
_____ Bladder Infection
_____ Dropped Bladder
_____ Incontinence
_____ Lack of Bladder Control
_____ Vaginal Itching
_____ Do You Crave: Salty

SPLEEN / STOMACH
_____ Difficulty Digesting Fatty Foods
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy
_____ Heaviness Anywhere in The Body
_____ Fatigue – On a Scale of 1 (low) – 10 (high):
1 2 3 4 5 6 7 8 9 10
_____ Hard to Get/Wake Up in The Morning
_____ Muscles Feel Tired Often
_____ Edema (Swelling) – Circle One:
Hands – Feet – Other: _____
_____ Easily Bruise
_____ Bad Breath
_____ Nausea / Vomiting
_____ Do You Crave: Sweet

MUSCULOSKELETAL

☐ Muscle Cramps? **If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Muscle Pain **/ Rheumatism? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Joint Swelling**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Tendonitis**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Arthritis**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Bursitis**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Rib Pain**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Upper Back Pain**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Lower Back Pain**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Neck Pain**? If So, Where?** _____	**What Makes It Feel Better?** _____
☐ Limited Range of Motion**? If So, Where?** _____	**What Makes It Feel Better?** _____

PLEASE MARK PROBLEM AREA(S) ON DIAGRAM MODELS:



1) Location of Pain:

Is the Pain: ☐ ☐ **Sharp** ☐ **Burning** ☐ **Fixed** ☐ **Tingling** ☐ **Numbness** ☐ **Aching** ☐ **Cramping** ☐ **Other:**

On a Scale of 1 (Low) – 10 (Unbearable):

Is the Pain Better with: ☐ **Rest** ☐ **Activity** ☐ **Ice** ☐ **Heat** ☐ **Cramping** ☐ **Other:** _____

2) Location of Pain:

Is the Pain: ☐ ☐ **Sharp** ☐ **Burning** ☐ **Fixed** ☐ **Tingling** ☐ **Numbness** ☐ **Aching** ☐ **Cramping** ☐ **Other:**

On a Scale of 1 (Low) – 10 (Unbearable):

Is the Pain Better with: ☐ **Rest** ☐ **Activity** ☐ **Ice** ☐ **Heat** ☐ **Cramping** ☐ **Other:** _____

Women Only

Part 1

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could you be Pregnant Now? ☐ Yes ☐ No

Number of : _____ Pregnancies Miscarriages _____

_____ Births Abortions _____

Post-Menopausal Bleeding? ☐ Yes ☐ No

Part 2

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflammatory Disease ☐ Ovarian Cysts

☐ STD's ☐ Hot Flashes

☐ Endometriosis ☐ Breast Cysts

☐ Yeas Infection / Vaginitis ☐ Mastitis

Part 1

When did your last Period Start? _____

Number of Days for Menstrual Cycle: _____

Number of Days Bleeding Lasts? _____

Describe Menstrual Flow:

☐ Moderate ☐ Heavy ☐ Light

☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Do You Suffer From:

☐ Cramping (Mark as appropriate):

☐ Cramping in Low Back ☐ In Groin Area

Is The Cramping/Pain:

☐ Mild ☐ Severe ☐ Mild ☐ Severe

☐ During Period ☐ During Period

☐ Before Period ☐ Before Period

☐ After Period ☐ After Period

Part 2

☐ Pre-Menstrual Syndrome (Mark as appropriate):

☐ Fluid Retention ☐ Cravings

☐ Fluctuating Emotions ☐ Irritability

☐ Tenderness in Breast ☐ Depression

☐ Fatigue ☐ Loose Stool

☐ Tender / Weepy

☐ Clotting (Mark as appropriate):

☐ Bright in Color ☐ Brown/Grainy

☐ Stringy ☐ Dark in Color

Size of Clots: ☐ Nickel ☐ Dime ☐ Larger

Do You Use Pain Medication? ☐ Yes ☐ No

What Kind of Medication?:

MEDICATIONS

Please list all prescription medications you use. Include those which you may only use occasionally.
Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: if need more space, use the last page.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS

Name	Purpose	How Long

NOTES / ANYTHING ELSE

_____

_____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

For Blue Root Acupuncture Staff – do not fill

Date:		
(Arm)	**BP**	**HR**
LA		
RA		