Seven Star Acupuncture & Apothecary
Patient Health History

Name: ____ **Date:** ______/______/______
(first) (middle) (last)

Date of Birth: _______/_______/_______
Age: ______
Birth Sex: M F
Pref. Gender: M F
Marital status: S M D W P
Email:____
Phone Number:____
May we leave you messages on your voice mail? Y N

1. When and where did you last receive health care? For what reason?__________________________
____
____

2. Please identify the health concerns that have brought you to our clinic, in order of importance below:

Condition **Past Treatment**

a. _______________________________ ____
How does this condition affect you?____

b. _______________________________ ____
How does this condition affect you?____

c. _______________________________ ____
How does this condition affect you?____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or **allergic** to (please include reaction):

____
____
____

4. Please list any **medications** (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____
____
____

5. Do you have any reason to believe you may be **pregnant**? Y N
If so, how far along are you? ____

6. Do you have any **infectious diseases**? Y N
If yes, please identify:
____

7. Family History: (Please circle any conditions that apply):

Cancer
Diabetes
High Blood Pressure
Heart Disease
Stroke
Mental Illness
Other:_________________________

8. Height: _______**Weight:** Currently: __________Past Maximum: _______When? __________

9. Blood Pressure: What is your most recent blood pressure reading? _______/_______
When was this reading taken? ________

10. Childhood Illness (please circle any that you have had):

Scarlet Fever
Diphtheria
Rheumatic Fever
Mumps
Measles
German Measles
Chicken Pox
Other:____________________________

11. Immunizations (please circle any that you have had):

Polio
Tetanus
Rubella/Mumps/Rubella
Pertussis
Diphtheria
Hib
Hepatitis B
Other:____________________________

12. Hospitalizations and Surgeries:

a. Date:________________
Reason:____

b. Date:________________
Reason:____

c. Date:________________
Reason:____

13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

a. Date:________________
Reason:____

b. Date:________________
Reason:____

c. Date:________________
Reason:____

14. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings
Anxiety
Mental Tension
Depression
Excessive Anger
Other:____________________________

15. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue
Slow Wound Healing
Chronic Infections
Chronic Fatigue Syndrome
Other:____________________________

16. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision
Eye Pain/Strain
Glaucoma
Glasses/Contacts
Tearing/Dryness
Impaired Hearing
Ear Ringing
Earaches
Headaches
Sinus Problems
Nose Bleeds
Frequent Sore Throats
Teeth Grinding TMJ/Jaw Problems
Hay Fever
Other:____________________________

17. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia
Frequent Common Colds
Difficulty Breathing
Emphysema
Persistent Cough
Pleurisy
Asthma
Tuberculosis
Shortness of Breath
Other:____________________________

18. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease
Chest Pain
Swelling of Ankles
High Blood Pressure
Palpitations/Fluttering
Stroke
Heart Murmur Rheumatic Fever
Varicose Veins
Other:____________________________

19. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers
Changes in Appetite
Nausea/Vomiting
Epigastric Pain
Passing Gas
Heartburn
Belching
Gall Bladder Disease
Liver Disease
Hepatitis B or C
Hemorrhoids
Abdominal Pain
Other:____________________________

20. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Kidney Stones
Painful Urination	Impaired Urination
Frequent UTI	Blood in Urine
Frequent Urination	Frequent Urination at Night
Heavy Flow	Other:____________________________

21. Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Clotting
Breast Lumps/Tenderness	Bleeding Between Cycles
Nipple Discharge	Menopausal Symptoms
Heavy Flow	Difficulty Conceiving
Vaginal Discharge	Painful Periods
Premenstrual Problems	Other:____________________________

22. Menstrual/Birthing History:

1. Age of First Menses: _______
2. # of Days of Menses: _______
3. Length of Cycle: _______
4. Birth Control Type: ________
5. # of Pregnancies: ________
6. # of Miscarriages: ________
7. # of Abortions: ________
8. # of Live Births: ________

23. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Penile Discharge
Prostrate Problems	Other:____________________________
Testicular Pain/Swelling	

24. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Low Back Pain
Muscle Spasms/Cramps	Leg Pain
Arm Pain	Joint Pain (Where?):________________
Upper Back Pain	Other:____________________________
Mid Back Pain	

25. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Loss of Balance
Paralysis	Seizures/Epilepsy
Numbness/Tingling	Other:____________________________

26. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid
Hypoglycemia
Hyperthyroid
Diabetes Mellitus
Night Sweats
Feeling Hot or Cold
Other:____________________________

27. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia
Cancer
Rashes
Eczema/Hives
Cold Hands/Feet

Is there anything else we should know?

____
____
____

28. Lifestyle:

a. Do you typically eat at least three meals per day? Y N
  If no, how many? ____________________
b. Exercise routine:____
c. Spiritual practice: ____
d. How many hours per night do you sleep? ________
  Do you wake rested? Y N
e. Occupation: __________________________________
  Hours/Week: _______
  Do you enjoy work? Y N
  Why/Why not? ____
f. Nicotine/Alcohol/Caffeine Use: ____
g. Have you experienced any major traumas? Y N
  Explain: ____
h. How many non-caffeinated, non-carbonated beverages do you drink per day?
  Example: water, herbal tea, etc.______________
i. Interests and hobbies: ____

29. How did you find Seven Star Acupuncture & Apothecary?

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____