HEALTHY QI & YOU
ACUPUNCTURE & CHINESE MEDICINE

125 West Richmond Ave., Suite D
Richmond, CA 94801
510.255.7461
Dr. Mi-Yung L. Rhee, L.Ac., DACM

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

In Chinese medicine, proper treatment depends on having a comprehensive understanding of a patient's health history, as well as lifestyle habits that may impact a patient's health status. While some questions may not seem relevant to the reason for your visit, the answers you choose to provide will determine how I can best help with your health concerns.
All questions contained in this questionnaire are **strictly confidential** and will become part of your medical record.

Full Name: ☐ M ☐ F ☐ _____		**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Primary or referring doctor:		**Date of last physical exam:**
What are your top 3 health concerns?		
Have you ever had acupuncture? ☐ Yes ☐ No **If yes, when was your last treatment?**		
Have you tried any other complementary or alternative methods of treatment? ☐ Yes ☐ No		
If yes, what were they?		
How did you hear about our clinic?		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations:	☐ Influenza	☐ MenACWY/MenB (Meningitis)	
	☐ Tetanus, diptheria & acellular pertussis *(Td/Tdap)*	☐ MMR *(Measles, Mumps, Rubella)*	
	☐ RZV/ZVL *(Shingles)*	☐ HPV *(Humn)*	
	☐ PVC13/PPSV23 *(Pneumonia)*	☐ Chickenpox	☐ Hepatitis A/B

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Do you get annual exams/preventative screenings?	☐ Yes	☐ No
If yes, which exams are you up-to-date on? ☐ Physical exam ☐ Blood Work ☐ Colon cancer screening		
For women: ☐ Annual gynecological exam ☐ Breast exam ☐ PAP smear		
For men: ☐ DRE (digital rectal exam) ☐ PSA (prostate-specific antigen)		
If no, when were your last exams/screenings?		

What diagnostic imaging have you had? ☐ Bone density scan ☐ Mammogram ☐ X-rays ☐ CT scan ☐ MRI ☐ Other (EKG, EEG)

Current Height:	**Current Weight:**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to Medications		
Name the Drug	Reaction You Had	
Allergies to Foods/Environmental Substances		
Food / Substance	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet & Nutrition	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	What do typically eat for your meals and snacks? And what time do you eat them?					
	Breakfast		Time:			
	Lunch		Time:			
	Dinner		Time:			
	Snacks		Time:			
	What kinds of foods or drinks do you regularly crave?					
	Do you favor "sweet" or "savory"? ☐ Sweet ☐ Savory ☐ A bit of both					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Environmental Exposures	Have you ever lived near a refinery, polluted area or in a home with leaded paint?				☐ Yes	☐ No
	If yes, please describe:					
	Have you ever lived in a house that had new carpeting, paint or other items that seemed to affect you?				☐ Yes	☐ No
	If yes, please describe:					
	Have you noticed any sensitivity to perfumes, gasoline or other scents/smells?				☐ Yes	☐ No
	If yes, please specify:					
	Do you use pesticides, herbicides or other chemicals in or around your home?				☐ Yes	☐ No
	If yes, please specify:					
	Are there any other environmental factors that might be impacting you?					

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy, please list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Have you experienced any change in your sex drive or libido?	☐ Yes	☐ No
	If yes, ☐ increased ☐ decreased		
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak to someone about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with someone?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS*		AGE	SIGNIFICANT HEALTH PROBLEMS*
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

*Significant Health Problems may include any of the following:

- Anemia
- Arthritis
- Asthma
- Cancer
- Cataracts
- Diabetes
- Epilepsy
- Gallbladder disease
- Glaucoma
- Hay fever/hives
- Heart disease
- High blood pressure
- Immunological Disorder (e.g., AIDS, MS, Guillain-Barre)
- Kidney disease
- Liver disease
- Mental illness (e.g., depression, Alzheimer's, dementia)
- Respiratory disease
- Stroke
- Thyroid problems (e.g., Grave's, Hashimoto's)
- Tuberculosis

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Rate your stress level on a scale of 1-10 during the average week with 1 being "hardly at all" and 10 being "unbearable". ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10		
Aside from the occasional bout of the blues, do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping? If yes, we will cover this in more detail later.	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Length of cycle (# of days between periods): _____ Duration of menses (# of days the period lasts): _____		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
If yes, please specify which of the above:		
Number of pregnancies _____ Number of live births _____ Number of abortions _____ Number of miscarriages _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine? If yes, when?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any problems with control of urination (aka incontinence)?	☐ Yes	☐ No
If yes, please describe. For example, when coughing or laughing.		
Have you had endometriosis or any ovarian cysts?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
If yes, please specify which of the above:		
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
If yes, please describe:		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine? If yes, when?	☐ Yes	☐ No
Do you feel burning discharge from your penis? If yes, how often?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam:		

COMPREHENSIVE REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms or problems in the following areas to a significant degree. We will discuss the areas that you indicate in greater detail during your initial visit.

☐ Skin	☐ Chest/Heart/Cardiovascular	☐ Recent changes in:
☐ Head/Neck	☐ Musculoskeletal *(Joints/Back/Bones)*	☐ Weight
☐ Eyes	☐ Gastrointestinal *(Appetite, Digestion, Bowels)*	☐ Energy level
☐ Ears	☐ Urinary	☐ Ability to sleep
☐ Nose/Sinuses	☐ Endocrine	
☐ Mouth/Throat	☐ Neurological	☐ Other pain/discomfort:
☐ Lungs/Respiratory	☐ Immune	