INOVA TRADITIONAL CHINESE MEDICINE CENTER

HEALTH HISTORY FORM

PERSONAL INFORMATION: Today's Date: _____

Patient Name: _____ Birth Date: ____/_____/_____

Supportive relationship(s)? ☐Yes ☐No | Spiritual Practice? ☐Yes ☐No If yes, _____

Any pets/farm animals? ☐Yes ☐No If yes, _____

Have you lived or traveled outside of the United States? ☐Yes ☐No If so, when & where? _____

_____

Have you or your family recently experienced any major life changes? ☐Yes ☐No If yes, please comment:

_____

Have you experienced any major losses in life? ☐Yes ☐No If yes, please comment: _____

_____

Do you enjoy your work? ☐Yes ☐No | Do you take vacations? ☐Yes ☐No | Do you spend time outside? ☐Yes ☐No

Stress level on a scale of 0-10 (10=most): ____ Source(s) of stress: _____

Stress Management: _____

Blood Type: _____ Current Height: _____ Current Weight: _____(lbs) Weight 1 Year ago: _____

Maximum Weight & When: _____ When during the day is your energy best? _____ Worst? _____

Are you currently under the current care of a physician? ☐Yes ☐No
If so, with whom: _____

If not receiving healthcare, when did you last receive health care? _____

What is/was the reason? _____

What are your most important health concerns and what treatments have been used?

1. _____ Treatment Used: _____
2. _____ Treatment Used: _____
3. _____ Treatment Used: _____
4. _____ Treatment Used: _____
5. _____ Treatment Used: _____

What led you to choosing this clinic? _____

_____

What do you know about us and how we work? _____

What **three** expectations do you have from today's visit at our clinic?

1) _____
2) _____
3) _____

What **three** long-term expectations do you have from working with our clinic?

1) _____
2) _____
3) _____

At this present time, how committed are you to addressing the underlying causes of your signs and symptoms that may relate to your lifestyle?
(0 = not committed and 10 = completely committed). Please circle.

0 1 2 3 4 5 6 7 8 9 10

What types of daily or weekly lifestyle habits do you feel support or strengthen your health?

_____

_____

What types of daily or weekly lifestyle habits do you feel DO NOT fully support your health?

_____

_____

What obstacles or challenges do you potentially anticipate that may undermine your health and following through on your treatment?

_____

_____

Who do you know that will sincerely support you consistently with the lifestyle change you will be making to regain your health and vitality?

_____

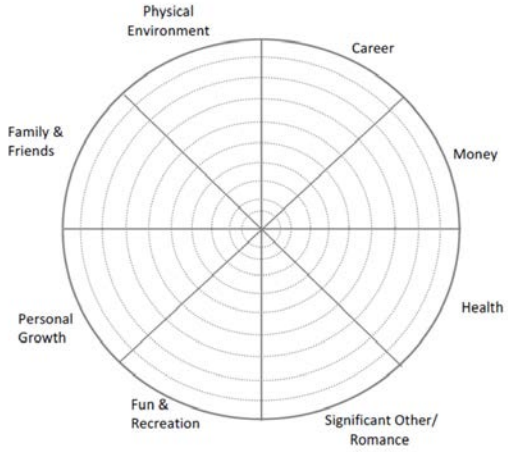
_____

What do you love doing; what brings you joy?

_____

_____

Wellness is achieved through various aspects of our lives. Using this pie chart, please shade your level of satisfaction of each area. Start shading from the center out to the edge of the circle. For example, if you are 50% satisfied in your career, you will shade starting from the center out and fill in half of that section of the pie chart (5 rings or bands). If you are 100% satisfied in your financial/money, then shade all 10 bands or rings the chart.



FAMILY HISTORY

Do you have a family history of any of the following (please check all that apply)?

- ☐ Cancer
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Stroke/TIA
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Anemia
- ☐ Hives
- ☐ High Blood Pressure
- ☐ Glaucoma
- ☐ Mental Health Illness
- ☐ Liver Disease

Any other relevant family history? _____

_____

CHILDHOOD/EARLY ADOLESCENT ILLNESSES

Which of the following have you had as a child?

- ☐ Scarlet Fever
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Asthma
- ☐ Diphtheria
- ☐ Measles
- ☐ Shingles
- ☐ Chronic Ear Infections
- ☐ Rheumatic Fever
- ☐ German Measles
- ☐ EBV (Mononucleosis)
- ☐ CMV (Cytomegalovirus)

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG or EKG's have you had?

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

ALLERGIES

Any drug? _____

_____

Any foods? _____

_____

Any chemical products? _____

_____

Any environmental/seasonal allergies? _____

_____

CURRENT MEDICATIONS

Please list all prescription medications, over the counter medications, vitamins and supplements you are taking (including herbs):

DIET/FOOD: Please list the most typical foods you eat for each meal.

General Eating Habits: _____

Breakfast: _____

Mid-AM Snack: _____

Lunch: _____

Mid-PM Snack: _____

Dinner: _____

Night Snack: _____

Water: _____

Soda: _____

Juices: _____

Alcohol: _____

Coffee: _____

Tea: _____

EXERCISE AND/OR PHYSICAL ACTIVITIES:

_____

_____

_____

BOWEL MOVEMENTS: Please fill in the chart below with information about your bowel movements:

a. Frequency	√	c. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

d. Intestinal Gas

☐ Daily ☐ Occasionally ☐ Excessive
☐ Present with pain
☐ Foul smelling
☐ Little odor

SLEEP HYGIENE:

Bedtime: _____Wakeup Time: _____ Hard to ☐ fall & ☐ stay asleep ☐ Unrefreshed upon awake ☐ Sleep well

MAIN INTERESTS OR HOBBIES:

REVIEW OF SYSTEMS: For this section, PLEASE CIRCLE
Y=Yes (a condition you have now), N=No (never had), and P= in the Past (significant problem of past).

GENERAL:							
Weight gain	Y	N	P	Weight loss	Y	N	P
Fatigue	Y	N	P	Weakness	Y	N	P
Fever or chills	Y	N	P	Obesity	Y	N	P
Comment:							

SKIN:							
Rashes	Y	N	P	Itchy skin	Y	N	P
Acne	Y	N	P	Hives	Y	N	P
Dryness	Y	N	P	Hair loss or changes	Y	N	P
Nail changes	Y	N	P	Color changes/Discoloration	Y	N	P
Eczema	Y	N	P	Psoriasis	Y	N	P
Comment: _____							

HEAD:							
Migraine headache	Y	N	P	Other headache	Y	N	P
Head injury	Y	N	P	Vertigo	Y	N	P
Dizziness	Y	N	P	Faintness	Y	N	P
Comment: _____							

EARS:							
Decreased hearing/Hearing loss	Y	N	P	Earache	Y	N	P
Ringing in ears (tinnitus)	Y	N	P	Itchy ears	Y	N	P
Ear infections	Y	N	P	Drainage from ear	Y	N	P
Comment: _____							

EYES:							
Watery or itchy eyes	Y	N	P	Redness	Y	N	P
Bags or dark circles under eyes	Y	N	P	Blurred vision	Y	N	P
Wearing glasses/contacts	Y	N	P	Double vision	Y	N	P
Cataracts	Y	N	P	Floaters	Y	N	P
Pain	Y	N	P	Glaucoma	Y	N	P
Comment: _____							

NOSE:							
Frequent colds	Y	N	P	Stuffiness	Y	N	P
Nose bleeds	Y	N	P	Hay fever	Y	N	P
Sinus problem	Y	N	P	Loss of smell	Y	N	P
Discharge	Y	N	P	Itching	Y	N	P
Comment: _____							

MOUTH & THROAT:							
Frequent sore throat	Y	N	P	Sores in mouth or throat	Y	N	P
Teeth grinding	Y	N	P	Gum problem/bleeding	Y	N	P
Dental cavities	Y	N	P	Hoarseness	Y	N	P
Difficulty swallowing (dysphagia)	Y	N	P	Jaw problem/TMJ	Y	N	P

Dry mouth	Y	N	P	Dry throat	Y	N	P
Dentures	Y	N	P	Thrush	Y	N	P
Sore tongue	Y	N	P	Amalgam fillings	Y	N	P

Comment: _____

NECK:

Pain	Y	N	P	Stiffness	Y	N	P
Swollen glands	Y	N	P	Lumps	Y	N	P

Comment: _____

BREASTS:

Pain or tenderness	Y	N	P	Nipple discharge	Y	N	P
Lumps	Y	N	P	Breast feeding	Y	N	P
Breast cancer	Y	N	P	Fibrocystic breasts	Y	N	P

Comment: _____

RESPIRATORY:

Cough (dry or wet, productive)	Y	N	P	Coughing up blood (hemoptysis)	Y	N	P
Wheezing	Y	N	P	Sputum (color & amount)	Y	N	P
Shortness of breath (dyspnea)	Y	N	P	Painful breathing	Y	N	P
Asthma	Y	N	P	Pneumonia	Y	N	P
Sleep apnea	Y	N	P	Frequent bronchitis/resp. infections	Y	N	P

Comment: _____

CARDIOVASCULAR:

Chest pain/discomfort/tightness	Y	N	P	Heart palpitations	Y	N	P
Shortness of breath with exertion	Y	N	P	Swelling (edema)	Y	N	P
Low blood pressure (hypotension)	Y	N	P	High blood pressure (hypertension)	Y	N	P
Heart disease	Y	N	P	Rheumatic fever	Y	N	P
Heart murmur	Y	N	P	Irregular heart beat (arrhythmia)	Y	N	P
Blood clots	Y	N	P	Stroke	Y	N	P
Difficulty breathing lying down (orthopnea)	Y	N	P	Sudden awakening from sleep with shortness of breath	Y	N	P

Comment: _____

GASTROINTESTINAL:

Increased appetite	Y	N	P	Decreased or loss of appetite	Y	N	P
Change in thirst	Y	N	P	Nausea	Y	N	P
Vomiting	Y	N	P	Ulcers	Y	N	P
Heartburn/Acid reflux/GERD	Y	N	P	Abdominal pain	Y	N	P
Stomach pain	Y	N	P	Abdominal bloating	Y	N	P
Belching or passing gas	Y	N	P	Constipation	Y	N	P
Diarrhea	Y	N	P	Loose stools	Y	N	P
Blood in stool	Y	N	P	Irritable Bowel Syndrome (IBS)	Y	N	P
Liver disease	Y	N	P	Gallbladder disease	Y	N	P
Jaundice (yellow skin)	Y	N	P	Hemorrhoids	Y	N	P
Inflammatory bowel disease (IBD)	Y	N	P	Celiac disease	Y	N	P
Non-Celiac Gluten Sensitivity	Y	N	P	Colon polyps	Y	N	P
Gastritis	Y	N	P	Colon cancer	Y	N	P

Comment: _____

URINARY:

Increased frequency	Y	N	P	Frequent urination at night (nocturia)	Y	N	P
Burning or Painful urination	Y	N	P	Frequent urinary tract infections (UTI)	Y	N	P
Urgency	Y	N	P	Incontinence	Y	N	P
Kidney stones	Y	N	P	Blood in urine	Y	N	P
Weak stream	Y	N	P	Urinary retention	Y	N	P

Comment: _____

GENITAL/REPRODUCTIVE ORGANS:

MALE

Pain with sex	Y	N	P	Discharge or sores	Y	N	P
Sexually transmitted diseases (STD's)	Y	N	P	Hernia	Y	N	P
Masses or pain	Y	N	P	Penile discharge	Y	N	P
Erectile dysfunction	Y	N	P	Low libido	Y	N	P
Testicular masses or pain	Y	N	P	Prostate disease	Y	N	P
Impotence	Y	N	P	Premature ejaculation	Y	N	P
Sexually active	Y	N	P	Sexual orientation:_____			

Comment: _____

FEMALE

Pain with sex	Y	N	P	Hot flashes/Menopausal symptoms	Y	N	P
Rash	Y	N	P	Itching	Y	N	P
Vaginal dryness	Y	N	P	Vaginal discharge	Y	N	P
Sexually transmitted diseases (STD's)	Y	N	P	Hernia	Y	N	P
Low libido	Y	N	P	Endometriosis	Y	N	P
Ovarian cysts	Y	N	P	Difficulty conceiving/Infertility	Y	N	P
Premenstrual Syndrome (PMS)	Y	N	P	Painful menses	Y	N	P
Abnormal PAP	Y	N	P	Heavy menstrual period	Y	N	P
Irregular menstrual period	Y	N	P	Birth control	Y	N	P
Clotting issue	Y	N	P	Polycystic Ovarian Syndrome (PCOS)	Y	N	P
Fibroids	Y	N	P	Pelvic inflammatory disease	Y	N	P
In Vitro Fertilization (IVF)	Y	N	P	Intrauterine Insemination (IUI)	Y	N	P
Sexually active	Y	N	P	Sexual orientation: _____			

Age of first menses: _____ Age of last menses (if menopausal): _____ Length of cycle in days: _____
Duration of menses in days: _____ Date of last annual exam/PAP: _____ Birth control method (if any): _____
Number of pregnancies: _____ Number of live births: _____ Number of miscarriages _____ and/or abortions: _____
Comment: _____

VASCULAR:

Calf pain with walking (claudication)	Y	N	P	Leg cramping	Y	N	P
Varicose veins	Y	N	P	Deep vein thrombosis (DVT)	Y	N	P

Comment: _____

MUSCULOSKELETAL:

Muscle pain	Y	N	P	Joint pain	Y	N	P
Back pain	Y	N	P	Swelling of joints	Y	N	P
Redness of joints	Y	N	P	Stiffness	Y	N	P
Weakness	Y	N	P	Sciatica	Y	N	P
Muscle spasms or cramps	Y	N	P	Muscle twitching	Y	N	P

Fibromyalgia	Y	N	P	Osteoarthritis	Y	N	P
Rheumatoid arthritis	Y	N	P	Bone loss (osteopenia/osteoporosis)	Y	N	P
Scoliosis	Y	N	P	Broken bones	Y	N	P
Gout	Y	N	P	Significant trauma from car accident(s)	Y	N	P

Comment: _____

NEUROLOGICAL:

Seizures	Y	N	P	Muscle weakness	Y	N	P
Memory problem	Y	N	P	Paralysis	Y	N	P
Numbness	Y	N	P	Tingling	Y	N	P
Easily stressed	Y	N	P	Loss of balance	Y	N	P
Bell's Palsy	Y	N	P	Multiple Sclerosis	Y	N	P

Comment: _____

HEMATOLOGIC:

Easy bleeding or bruising	Y	N	P	Anemia	Y	N	P
Thalassemia	Y	N	P	Cold hands/feet	Y	N	P

Comment: _____

ENDOCRINE:

Type I Diabetes	Y	N	P	Type II Diabetes	Y	N	P
Hypothyroidism	Y	N	P	Hyperthyroidism	Y	N	P
Parathyroid problem	Y	N	P	Adrenal disorder	Y	N	P
Excessive thirst	Y	N	P	Excessive hunger	Y	N	P
Heat/cold intolerance	Y	N	P	Hypoglycemia	Y	N	P
Sweating (increased/decreased)	Y	N	P	Night sweats	Y	N	P

Comment: _____

PSYCHIATRIC:

Depression	Y	N	P	Anxiety	Y	N	P
Significant Emotional Stress	Y	N	P	Mood swings	Y	N	P
Eating disorder	Y	N	P	Alcoholism	Y	N	P
Suicide	Y	N	P	Drug addiction	Y	N	P

Comment: _____

IMMUNE SYSTEM:

Reaction to vaccinations	Y	N	P	Autoimmune disease	Y	N	P
Chronic fatigue syndrome	Y	N	P	Chronic infections	Y	N	P
Slow healing	Y	N	P	Lyme disease	Y	N	P
HIV/AIDS	Y	N	P	Chronic swollen glands	Y	N	P

Comment: _____