Susan Ko, L.Ac. & Sung Kim, L.Ac.

HEALTH HISTORY for WOMEN

Date: ____ / ____ / _____

Name:	Sex:	Age:

Address:	City:	State:	Zip Code:

Home Phone #:	Other Phone #: Work Cell Other	Email:

Date of Birth:	Employer:	Occupation:

Primary Physician and Phone Number:	Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: _____

Emergency Contact:	Usual Blood Pressure:

Weight:	Weight One Year Ago:	How did you hear of our clinic?

Are you or may you be currently pregnant?	Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when ____/____/____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer	❒	_____	❍
Diabetes	❒	_____	❍
Hepatitis	❒	_____	❍
High Blood Pressure	❒	_____	❍
Heart Disease	❒	_____	❍
Stroke	❒	_____	❍
Seizure Disorder	❒	_____	❍
Thyroid Disease	❒	_____	❍
Asthma	❒	_____	❍
Pacemaker	❒	_____	❍
Osteoporosis	❒	_____	❍
Herpes	❒	_____	❍
AIDS / HIV	❒	_____	❍
Other STD	❒	_____	❍
Rheumatic Fever	❒	_____	❍
Alcoholism	❒	_____	❍
Allergies type(s)?	❒	_____	❍
_____			
Mental Illness	❒	_____	❍
Kidney Disease	❒	_____	❍
Anemia	❒	_____	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No
If so, what and how often:

_____
_____
_____

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

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HEALTH HISTORY for WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks
- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats
  When_____ am / pm
  Where on body _____ _

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?
- ❒ Edema / Swelling _____
- ❒ Rashes _____
- ❒ Itching _____
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N
- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW ——— HIGH

- ❒ Sudden energy drop
  Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night _____
- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate: How often? _____
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?
- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness
- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color_____)
- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

MENSES

Age at first menses: _____
Length of full cycle: _____ days (i.e. 28)
Length of menses: ____ days (i.e. 3-4)
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: _____ premature _____
# of abortions / miscarriages: _____

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
- ❒ Before bleeding
- ❒ First day
- ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)

MENOPAUSE

Age at last menses: _____
Year changes began: _____

- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week

- ❒ Vaginal dryness
- ❒ Loss of sex drive