New Patient Health History

Utah Family Acupuncture and Herbs, LLC
177 West 700 South, SLC, UT 84101

Name: _____ Today's Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M___F___ MtoF__ FtoM__ Marital status:S___M___D___W___

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Emergency Contact Name: _____Phone:_____

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. 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? _____	

4. If applicable, please list any foods, drugs, or medications you are <u>hypersensitive or **allergic**</u> to (please include reaction):

_____

_____

5. Please list **<u>ALL</u>** medications (prescribed and over-the-counter), vitamins and supplements you are <u>currently taking</u>:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases (hepatitis, tuberculosis, etc.)? Y N

If yes, please identify: _____
Do you have a <u>pacemaker</u>? Y N

8. **Family History:** <u>Father</u> <u>Mother</u> <u>Brothers</u> <u>Sisters</u> <u>Spouse</u> <u>Children</u>

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Your Height: _____** **Your Weight: _____**

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Vaccinations**: Have you recently had any vaccinations? Please write the name(s) and date(s) below:

_____

_____

13. **Hospitalizations and Surgeries:**

Reason	When
_____	_____
_____	_____
_____	_____

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

Reason	When
_____	_____
_____	_____
_____	_____

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

Mood Swings Nervousness Mental Tension

16. **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

17. **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

18. **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 Respiratory Problems: _____		

19. **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 Murmurs	Rheumatic Fever	Varicose Veins

20. **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

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

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

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

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

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menstrual flow: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Your period comes every _____days	6. # of Miscarriages: _____	

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

Sexual Difficulties	Prostrate Problems	Testicular Pain/Swelling	Penile Discharge

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

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

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

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **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

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

Anemia **Cancer** (please describe below) Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

29. **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. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine Use: _____

h. Alcohol (number of drinks per *week*): _____

i. Caffeine (number of drinks per *day*, i.e. coffee, tea): _____

j. Have you experienced any major traumas? Y N Explain: _____

_____

k. Interests and hobbies: _____

How did you hear about us? _____

Print your email address if you'd like to receive specials: _____

Kindly give 24 hours notice in the event you need to cancel an appointment