Seattle Naturopathic and Acupuncture Center

Dr. Diane Lee, ND, L.Ac

Health History Questionnaire

By completely filling out this form, you will help us help you. All answers will be *absolutely confidential*.
If you have any questions, please don't hesitate to ask. Thank you!

Name: _____ Today's Date: _____ DOB: _____

Age: _____ Sex: M / F Primary phone: Cell / Home / Work _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Occupation: _____

Parents' names *(if patient is a minor)*: _____ _____

Who referred you to our clinic? _____

Name(s) of other healthcare provider(s)

Medical: _____ Naturopathic: _____

Chiropractic: _____ Other: _____

Primary Health Concerns

Why are you coming to our clinic today? _____
_____

When did your problem(s) begin? Be specific. _____
_____
_____
_____

Patient Medical History

Please circle and date.

Allergies (drugs, chemicals, foods)	High blood pressure	Seizures
Cancer	Hepatitis	Significant trauma *(auto accidents, falls, etc.)*
Diabetes	Rheumatic Fever	Venereal Diseases
Heart Disease	Surgeries	Other major illness(es)

Family Medical History

Please indicate family member, and if on (F)ather or (M)other's side of family.

Allergies	Cancer	High blood pressure	Seizures
Asthma	Diabetes	Heart Disease	Stroke

Occupational stress

(chemical, physical, psychological)

_____
_____
_____

Describe your weekly exercise

_____
_____
_____

Current medicines

List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

_____
_____
_____

Known allergies

_____
_____

Diet

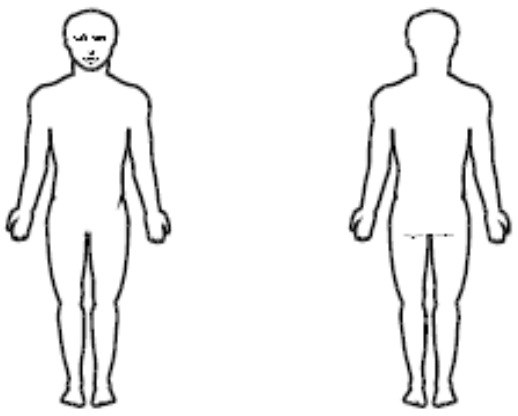
Are you or have you ever been on a restricted diet? Y / N
If so, what kind? _____

Please describe your average daily diet.
Morning: _____
_____
Afternoon: _____
_____
Evening: _____
_____

How many packs of cigarettes do you smoke each week? _____

How many servings of the following do you drink per week? Coffee _____ Soda _____ Tea _____ Alcohol _____

Please indicate painful or distressed areas on the diagram to the right.



Please check if the following symptoms are a current or recurring problem.

General

Poor appetite	Night sweats	Weight gain
Poor sleep	Sweat easily	Weight loss
Fatigue	Change in appetite	Chills
Cravings	Bleed or bruise easily	Fevers
Sudden energy drop (if so, when?)	Strong thirst	Peculiar tastes or smells

Other? _____

Skin and Hair

Rashes	Change in hair or skin texture	Recent moles
Itching	Loss of hair	Ulcerations
Eczema	Dandruff	Pimples

Other hair or skin problems? _____

Head, Eyes, Ears, Nose, and Throat

Using glasses	Earaches	Sinus problems
Color blindness	Poor hearing	Nose bleeds
Night blindness	Ringing in ears	Headaches
Eye strain	Mercury tooth fillings	Concussions
Eye pain	Tooth pain	Jaw clicks or pain
Blurry vision	Recurrent sore throats	Facial pain
Cataracts	Sores on lips or tongue	Neck pain

Other? _____

Cardiovascular

High blood pressure	Fainting	Cold hands or feet
Low blood pressure	Chest pain	Swelling of hands
Irregular heartbeat	Varicose veins	Swelling of feet
Dizziness	Blood clots	Other _____

Respiratory

Difficulty breathing	Asthma	Coughing blood
Cough	Bronchitis	Pain with deep breathing
Production of phlegm (if so, what color?)	Pneumonia	Other _____

Gastrointestinal

Indigestion	Abdominal pain or cramps	Rectal pain
Gas	Nausea	Hemorrhoids
Bad breath	Vomiting	Blood in stool
Constipation	Chronic laxative use	Diarrhea

Other? _____

Genito-Urinary

Frequent urination	Unable to hold urine	Kidney stones
Urgency to urinate	Decrease in flow	Impotency
Pain upon urination	Distinctive or odd color urine	Sores on genitals
Blood in urine	Waking to urinate	Other _____

Gynecology and Pregnancy

Unusual menses	Irregular periods	Clots
Heavy	Painful periods	Vaginal sores
Light	Breast tenderness	Vaginal discharge

Changes in body or emotions prior to menstruation: _____

Do you practice birth control? Y / N
If yes, what type and for how long? _____

_____ Number of pregnancies	_____ Age of first menses
_____ Number of births	_____ Duration of menses
_____ Number of miscarriages	_____ Days between menses
_____ Number of abortions	_____ Start date of last menses
	_____ Date of last PAP exam

Musculoskeletal

Neck pain	Back pain	Shoulder pain
Knee pain	Foot/ankle pain	Hip pain
Hand/wrist pain	Muscle pain	Muscle weakness

Other joint or bone problems: _____

Neuro-psychological

Loss of balance	Depression	Concussion
Quick temper/irritability	Susceptible to stress	Seizures
Poor memory	Dizziness	Areas of numbness
Anxiety	Lack of coordination	Other _____

Have you ever been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

Any other neurological or psychological problems? Y / N

Please describe any other problems you would like to discuss:

_____
_____
_____
_____
_____
_____
_____
_____