Infinity Acupuncture & Sports Medicine, LLC
Patient Health History

Name: _____ Date: _____/_____/_____
(First) (Middle) (Last)

Address: _____

Email: _____ Phone: _____

Date of Birth: _____/_____/_____ Age: ____ Gender: M/F/T/_____ Marital Status: S M D W

Successful health care and preventative medical care are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

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

For what reason?_____

2. Has your case been referred to an attorney? Yes No

3. Please identify the health concerns that have brought you to Infinity Acupuncture & Sports Medicine 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?	_____
d. _____	_____
How does this condition affect you?	_____

4. Please list any foods, drugs, or medications to which you are allergic or hypersensitive (please include reaction)_____

_____

5. Please list any medications (prescribed or over-the-counter), vitamins, and/or supplements you are currently taking: _____

_____

_____

6. Do you have any reason to believe you may be pregnant? Yes No

If so, how many weeks pregnant are you? _____

7. Do you have any infectious diseases? Yes No If yes, please specify _____

8. **Family History**:

	Father	Mother	Brothers	Sisters	Spouse	Children
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. Height: _____ Weight: _____ Past Maximum: _____ When? _____

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/Diptheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Measles Pertussis Diptheria Hib Hepatitis B

Others: _____

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 Varicose Veins
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Kawasaki Syn.

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
Gall Bladder Disease Belching Liver Disease
Heartburn 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 Nighttime Urination

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 Painful Periods
Bleeding Between Cycles Menopausal Symptoms Difficulty Conceiving

23. **Menstrual/Birthing History:**

Age of First Menses: _____ Birth Control Type: _____
# of Days of Menses: _____ # of Pregnancies: _____
Length of Cycle: _____ # of Miscarriages: _____
# of Live Births: _____

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

Sexual Difficulties Prostate 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 & Where _____

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

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

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

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitis

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 Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. **Lifestyle:**

a. Do you eat at least 3 meals per day? Yes No If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Yes No

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

f. Occupation: _____ Employer: _____ Hours per Week: ____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Yes No

If yes, please explain: _____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

How did you hear about us? _____