DiLuv Acupuncture

Denise DiLuv, DOM., AP, LMT, RDH
20406 Edgewater Drive
Port Charlotte, Florida 33952

941-255-9607

HEALTH HISTORY QUESTIONAIRE

Name ____ **Date** _________________________

Address:____

Phone:____________________ **Email:**_____________________________**DOB:**____/_____/20_____

Chief Concern____

____

Other Concerns ____

____

____

When did these problems begin? (Be Specific) ____

____

____

How do these complaints affect your daily activities?(work, sleep, relationships)__________________

____

____

Have you been diagnosed? If so, what is the diagnosis? _____________________________________

____

What kinds of treatments have you tried? ____

____

Are you Pregnant? ______________________ **Do you have a pacemaker?** ______________________

Medical History for the past six (6) months (include dates) __________________________________

____

Family Medical History & significant illness (please circle) Cancer Diabetes Hepatitis
Heart Disease High Blood Pressure Stroke Rheumatic Fever Seizures Thyroid Disease
Venereal Disease Allergies Asthma Other____

Surgeries ____

____

____

(over)

Significant Trauma (auto accidents, injuries, etc.) ____
____
____

Your Birth History (prolonged labor, forceps delivery, etc.) ______________________________________
____

Allergies (drugs, chemicals, foods) ____
____

Medications taken in the last two (2) months (include vitamins, drugs, herbs, birth control and over the counter) ____
____
____

Lifestyle / Occupational Stress (chemical, physical etc.) ____
____

Do you exercise? ____________ **How Regularly**? ____________ **Describe** _______________________
____

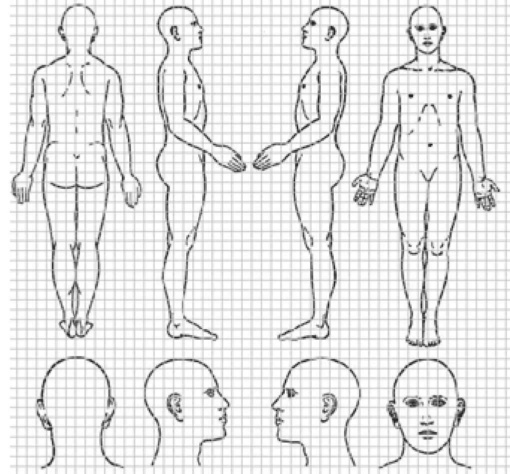
Have you ever been on a restricted diet? ______________ **What Kind**? __________________________
____

Please describe your average daily diet including meals and snacks:
Morning: ____
____
Afternoon: ____
____
Evening: ____
____

Is there anything else you would like us to know about you? ____________________________________
____
____

(over)

Indicate any painful or distressed areas



Please check if you have had within the last three (3) months:

____ Poor appetite
____ Fevers
____ Sweats easily
____ Localized weakness
____ Peculiar tastes or smells
____ Sudden thirst (cold or hot drinks)
____ Poor sleeping
____ Chills
____ Tremors
____ Poor balance
____ Weight loss
____ Fatigue
____ Night sweats
____ Cravings
____ Change in appetite
____ Weight gain

Sudden energy drop (what time of day?) ____________________

SKIN and HAIR

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

Any other hair or skin problems? ____________________

HEAD, EYES, EARS, NOSE and THROAT

____ Dizziness
____ Glasses
____ Poor Vision
____ Cataracts
____ Ringing in ears
____ Sinus problems
____ Grinding teeth
____ Teeth problems
____ Concussions
____ Eye strains
____ Night blindness
____ Blurry vision
____ Poor hearing
____ Nose bleeds
____ Facial pain
____ Jaw clicks
____ Migraines
____ Eye pain
____ Color blindness
____ Earaches
____ Spots in front of eyes
____ recurrent sore throats
____ Sores on lips or tongue

(over)

HEADACHES? Where and when?____

Any other head and / or neck problems? ____

CARDIOVASCULAR

_____ High blood pressure _____ Low blood pressure _____ Chest pain

_____ irregular heartbeat _____ dizziness _____ Fainting

_____ Cold hands or feet _____ swelling of hands _____ Swelling of feet

_____ Blood clots _____ Phlebitis _____ Difficulty breathing

ANY OTHER HEART OR BLOOD VESSEL PROBLEMS?_____________________________

____

RESPIRATORY

_____ Cough _____ Coughing blood _____ Asthma

_____ Bronchitis _____ Pneumonia _____ Pain with deep breath

_____ Difficulty breathing when lying down

_____ Production of Phlegm What color?__________

Any other lung problem? ____

GASTROINTESTINAL

_____ Nausea _____ Vomiting _____ Diarrhea

_____ Constipation _____ Gas _____ Belching

_____ Black stools _____ Blood in stools _____ Indigestion

_____ bad breath _____ Rectal pain _____ Hemorrhoids

_____ Chronic laxative use

Any other problems with your stomach or intestines?______________________________

GENITO-URINARY

_____ Pain on urination _____ frequent urination _____ Blood in urine

_____ Urgency to urinate _____ unable to hold urine _____ Kidney stones

_____ decrease in flow _____ impotency _____ Sores on genitals

Do you wake up to urinate? How often? ___________________________________

Any particular color to your urine? _______________________________________

Any other problems with your genitals or urinary system? ___________________________

(over)

PREGNANCY & GYNOCOLOGY

____ Number of pregnancies
_____ Number of births
_____ Premature birth
____ Miscarriages
_____ Abortions
_____ Age @ first menses
____ Period between menses
_____ Duration
_____ first day of last menses
____ Unusual character (heavy or light)
_____ Irregular periods
____ Painful periods
_____ Clots
_____ Last PAP
____ Vaginal discharge
_____ Vaginal sores
_____ Breast lumps
____ Changes to body / psyche prior to discharge

Do you practice birth control?____ What type and for how long?________________________________

MUSCULOSKELATAL

____ Neck pain
_____ Muscle pains
_____ Knee pains
____ back pain
_____ Muscle weakness
_____ Foot/ankle pains
____ Hand/wrist pains
_____ Shoulder pain
_____ Hip pain

ANY OTHER JOINT OR BONE PROBLEMS? ____

NEUROPSYCHOLOGICAL

____ Seizures
_____ Dizziness
_____ Loss of balance
____ Areas of numbness
_____ Lack of coordination
_____ Poor memory
____ Concussion
_____ Depression
_____ Anxiety
____ Bad temper
_____ Easily susceptible to stress

Have you ever been treated for emotional problems?__________________________________

Have you ever considered or attempted suicide? ______________________________________

Any other neurological or psychological problems? ____________________________________

COMMENTS:

(over)