

TCMCH Community Short Health History Questionnaire

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Name _____ Date of Birth _____ Today's Date _____

Age: _____ Height: _____ Weight: _____ Sex: M F

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Office Phone _____ Cell Phone _____

Occupation: _____ Employed by: _____

In Case of
Emergency Contact: _____ Telephone: _____

Major Complaint/s: _____

Secondary signs and/or symptoms: _____

Medication/drug/herbs you are currently taking: _____

List Surgeries/Operations you have had and when: _____

Medical History – Check if they apply

<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Communicable/STD Disease	<input type="checkbox"/> Sudden weight (Loss/Gain)	<input type="checkbox"/> Stroke	
<input type="checkbox"/> STD	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Gallstones

Family History: Any Member of your family had any of the above? Which member and what did they have?

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE LAST 3 MONTHS

General:

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Heavy appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Heavy sleep
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Tremors	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Cold abdomen
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Cravings	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Peculiar tastes/smells	
<input type="checkbox"/> Sudden energy drop at _____ (time)			
<input type="checkbox"/> Strong thirst (cold/hot drinks _____)		<input type="checkbox"/> Bleed or bruise easily (where) _____	

Skin and Hair:

<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching	<input type="checkbox"/> Ulcerations
<input type="checkbox"/> Eczema	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Mole Changes
<input type="checkbox"/> Change in hair/skin texture	<input type="checkbox"/> Purpura	<input type="checkbox"/> Other hair or skin problem _____		

Head, Eyes, Ears, Nose & Throat:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Concussions	<input type="checkbox"/> Migraines	<input type="checkbox"/> Glasses
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Night blindness
<input type="checkbox"/> Color blindness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Earaches
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Mucus	<input type="checkbox"/> Dry throat	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Copious saliva
<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Gum problems	<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> Recurrent sore throats _____ month	
<input type="checkbox"/> Sores on lips or tongue	<input type="checkbox"/> Headaches		
<input type="checkbox"/> Other head or neck problems _____			

Cardiovascular:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Swelling in hands/feet
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Other

Respiratory:

<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Difficulty in breathing when lying down		<input type="checkbox"/> Tight chest
<input type="checkbox"/> Production of phlegm _____ What color? _____		<input type="checkbox"/> Other lung problems	

Gastrointestinal:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	Bowel Movement:
<input type="checkbox"/> Gas	<input type="checkbox"/> Belching	<input type="checkbox"/> Black Stools	_____ Frequency
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Hemorrhoids	_____ Color
<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Sensitive abdomen	_____ Odor
			_____ Texture/form
<input type="checkbox"/> Pain or cramps	<input type="checkbox"/> Laxative use: _____ /week; type _____		

Genito-Urinary:

<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Abdominal pain/cramps
<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Impotency	<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Wake up to urinate <input type="checkbox"/> Yes <input type="checkbox"/> No		How often? _____ Other genital or urinary system problems? _____		

Pregnancy and Gynecology

<input type="checkbox"/> Number pregnancies	<input type="checkbox"/> Number births	<input type="checkbox"/> Premature births	Miscarriages
<input type="checkbox"/> Age at first menses _____	<input type="checkbox"/> Period (days) _____	<input type="checkbox"/> Duration _____	Irregular periods
		<input type="checkbox"/> Last PAP	Last menses _____
<input type="checkbox"/> Flow (describe)	<input type="checkbox"/> Clots	<input type="checkbox"/> Breast lumps	Menopause _____
<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Vaginal sores		
<input type="checkbox"/> Birth control: type and duration _____		<input type="checkbox"/> Body/psyche changes prior to menstruation _____	

Musculoskeletal:

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle Pains pain	<input type="checkbox"/> Back pains (where)	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Joint pains (where)
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pain	<input type="checkbox"/> Hip pain	

Neuropsychological:

<input type="checkbox"/> Seizures	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Concussion
<input type="checkbox"/> Depression	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Easily stressed
<input type="checkbox"/> Treated for emotional problems?	<input type="checkbox"/> Confusion	<input type="checkbox"/> Panic	<input type="checkbox"/> Considered/attempted suicide