



**Acupuncture For Life**  
Stroke, Pain, Stress, Quit Smoking, and more

**Caroline Chen, L.Ac.**  
(832) 660-5281  
www.acuforlife.com

**HEALTH HISTORY**  
(confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Please check (✓) symptoms you currently have or have had in the past year.			
<p><b>General</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Fevers</li> <li><input type="checkbox"/> Forgetfulness</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Sweats</li> <li><input type="checkbox"/> Weight gain</li> <li><input type="checkbox"/> Weight loss</li> </ul> <p><b>Eye, Ear, Nose, Mouth, Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Ear discharge</li> <li><input type="checkbox"/> Eye pain/strain</li> <li><input type="checkbox"/> Glasses</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Olfactory problems</li> <li><input type="checkbox"/> Recurrent sore throat</li> <li><input type="checkbox"/> Red / Inflamed eye</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Sores on lips / tongue</li> <li><input type="checkbox"/> Taste change</li> <li><input type="checkbox"/> Teeth problems</li> <li><input type="checkbox"/> Vision – halos</li> </ul>	<p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Coughing blood</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Phlegm production</li> <li><input type="checkbox"/> Recurrent bronchitis</li> <li><input type="checkbox"/> Shortness of breath</li> </ul> <p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Irregular heart beat</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Swelling of ankles</li> <li><input type="checkbox"/> Varicose veins</li> </ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal pain</li> <li><input type="checkbox"/> Black stools</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Blood in stools</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Gas</li> <li><input type="checkbox"/> Heartburn / Reflux</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Poor appetite</li> <li><input type="checkbox"/> Stomach pain</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomiting blood</li> </ul>	<p><b>Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal urine color</li> <li><input type="checkbox"/> Blood or pus in urine</li> <li><input type="checkbox"/> Burning urination</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Kidney stone</li> <li><input type="checkbox"/> Poor bladder control</li> <li><input type="checkbox"/> Urgency to urinate</li> </ul> <p><b>Musculoskeletal</b> Pain, weakness, and/or numbness in:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arms</li> <li><input type="checkbox"/> Back</li> <li><input type="checkbox"/> Feet</li> <li><input type="checkbox"/> Hands</li> <li><input type="checkbox"/> Hips</li> <li><input type="checkbox"/> Joints</li> <li><input type="checkbox"/> Legs</li> <li><input type="checkbox"/> Muscle</li> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Shoulders</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood not clotting</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Discoloration</li> <li><input type="checkbox"/> Lumps in groins</li> <li><input type="checkbox"/> Lumps underarm</li> <li><input type="checkbox"/> Skin problem</li> </ul> <p><b>Neurological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Handwriting change</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Tremor / clumsiness</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Vertigo / drowsiness</li> </ul> <p><b>Men Only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Genital pain</li> <li><input type="checkbox"/> Impotence</li> <li><input type="checkbox"/> Lump in testicles</li> <li><input type="checkbox"/> Penis discharge</li> </ul> <p><b>Women Only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal Pap Smear</li> <li><input type="checkbox"/> Bleeding between periods</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Contraceptives</li> <li><input type="checkbox"/> Irregular periods</li> <li><input type="checkbox"/> Menopausal</li> <li><input type="checkbox"/> Painful periods</li> <li><input type="checkbox"/> Sores on genitalia</li> <li><input type="checkbox"/> Vaginal discharge</li> </ul> <p>Number of:</p> <p>___ Pregnancies</p> <p>___ Miscarriages</p> <p>___ Children</p> <p>___ Abortions</p> <p>Date of: Last menstrual period: _____</p> <p>_____</p> <p>Last Pap Smear: _____</p> <p>_____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p>