Chinese Medicine Health Questions

Name: _____

Date: _____

This is a “one size fits all” type of questionnaire. Many of these questions may not seem to be applicable to your current conditions. However, Chinese medicine is a form of holistic health care. Only by understanding the person as a whole that we will be able to formulate an effective treatment plan for you.

Please answer the questions in short form in the space available. Thank you in advance for taking the time to do this. It will allow us for longer treatment time on your first visit. However, you do have a choice not to answer these questions. In such case, we will go through them together on your first visit.

CHILLS AND FEVER
Do you ever have any of the following? □ chills □ fever □ both chills and fever
If so, please describe (how often, how long, time of day or circumstances, etc)

PERSPIRATION
Do you perspire? Y N
If so, do you perspire after slight exertion? Y N
Any odors or color to the perspiration?
Do you perspire at night? Y N
Do you perspire spontaneously? Y N

HEAD AND BODY
Do you experience headaches? Y N
If yes, what time of day do the headaches begin?
Where do the headaches occur (front, back, side of head, etc)?
What is the character of the headache (sharp, dull, throbbing, etc)?
Is there anything that makes the headaches better or worse (pressure, hot or cold applications?)

Do you ever experience dizziness? Y N
If yes, please describe:

Do you ever experience pain anywhere in your body? Y N
If yes, where?
How often?
Type of pain (dull, sharp, throbbing, etc):
Does the pain stay in one location or does it move around?
Does anything make it better or worse?

Do you have any other symptoms associated with the pain (fatigue, nausea, etc)?

Do you ever experience swelling in your joints? Y N
If yes, which joints?
How often?
Is there any redness or heat in the joints that occurs with the swelling? Y N
Does anything make it better or worse?

Do you ever experience numbness anywhere in your body? Y N
If yes, where?
How often?
Does anything make it better or worse?

CHEST AND ABDOMEN

Do have any chest pain? Y N
If yes, where?
How often?
Type of pain (sharp, dull, crushing, heavy, aching, etc):
Does the pain radiate anywhere?

Does anything make it better or worse?

Do you ever have palpitations? Y N
Do you ever have anxiety? Y N
Do you have asthma? Y N
Do you have a cough? Y N
If yes, is there a particular time of day that it occurs?
Is the cough strong (hacking) or weak? _____ Is it wet or dry? _____
Do you have any phlegm/sputum with the cough? Y N
If yes, what is the colour and consistency (thick, watery, foamy, etc)?

Do you have any difficulty breathing? Y N
If yes, please describe:

Do you ever experience abdominal distension, pain, or a feeling of fullness in the abdomen? Y N
If yes, where? (upper, lower, middle)
How often?
Does anything make it better or worse? (bowel movements, eating, etc)?

If there is pain, describe the nature (sharp, dull, cramping):

APPETITE, THIRST AND TASTE
How is your appetite?
Any changes in your appetite?

Any weight gain or loss?
If so, please describe amount and over what period of time:

How is your thirst?
How much water/fluid do you drink per day?
Any preference for hot or cold drinks?
Do you tend to sip or gulp your drinks?

Any particular food cravings?

Any unusual tastes in your mouth? (e.g., bitter, sweet, salty, etc)?

Any bloating or gas?
Any belching, acid reflux, or vomiting?

STOOL & URINE
Do you get constipated or have diarrhea?
□ Normal □ constipated □ diarrhea □ alternating constipation and diarrhea
What is the consistency of your stool (hard, formed, loose, watery, soft, dry, etc)?
Number of bowel movements per day:
Is the colour of the urine clear, yellow, dark, or cloudy?
Any pain or difficulty with either urination or defecation?

Any undigested food, mucous, or blood in the stool?

SLEEP
Do you sleep well? Y N
Hours of sleep per night:
Do you have any trouble falling or staying asleep? Y N
Please describe:

Do you frequently dream or have nightmares?

Do you wake up and feel refreshed? Y N

EARS & EYES
How is your hearing?
Have you noticed any changes to your hearing recently?
Have you experienced deafness in either (specify) or both ears?
If yes, was the hearing loss sudden or gradual?
Do you ever experience ringing in either (specify) or both ears?
If yes, Is the ringing □ low-pitched? □ high-pitched?
Is the ringing □ constant? □ comes and goes?
Did the ringing □ begin suddenly? □ come on gradually?
Is there anything that makes the ringing better or worse (e.g., pressure)?
How is your vision?
Have you noticed any changes to your vision lately?
Do you ever experience:
□ Blurred vision? □ Red eyes? □ Night blindness? □ Dry eyes? □ Floaters?

MENSES AND LEUKORRHEA (Females)
Is your period the same each month? Y N
Number of days in cycle: How many days is your period?
What is the quantity of your flow?
□ excessive □ moderate □ small amount □ extremely small amount
What colour is your flow (dark red, bright red, brown, etc)?
Any clots in your period? Y N
Any vaginal discharge? Y N
If so, please describe the colour, consistency, and odour

Is there anything else that you would like to mention that has not been covered or feel it is important for me to be aware of?

Review of Systems

Please place a checkmark (√) next to any of the following symptoms that you currently experience and a (P) next to any that you have had in the past:

SKIN & HAIR							
Rashes		Itching		Eczema		Acne	
Psoriasis		Boils/Cysts		Hives		Warts	
Lumps		Dandruff		Dryness		Nail changes	
New/Changed moles		Skin Colour changes		Change in hair texture		Hair loss	
Other							

EYES							
Glasses/contacts		Far-sighted		Near-sighted		Double vision	
Colour blindness		Night blindness		Sensitivity to sun		Dryness	
Pain		Redness		Itching		Discharge	
Blurring		Excessive tearing		Spots/Floaters		Blind spot	
Glaucoma		Cataracts	Other				

EARS							
Ringing		Discharge		Pain/Aches		Deafness	
infections		Wax build-up		Ear tubes		Other	

NOSE & SINUSES							
Allergies		Loss of smell		Post nasal drip		Nosebleeds	
Dryness		Sinus infections		Sinus pain		Nasal congestion	
Sleep apnea		Snoring		Nasal Polyps		Other	

MOUTH & THROAT							
Loss of Taste		Ulcers/sores		Cold sores		Pain/Soreness	
Frequent Sore throat		Hoarseness		Tonsillitis		Grinding/ Clenching	
Phlegm/Mucous		Jaw pain/clicking		Enlarged glands		Facial pain/tics	
Other							

HEAD & NECK							
Headache		Injury		Lumps		Pain/stiffness	
Swollen glands		Swollen lymph nodes		Goitre		Other	

RESPIRATORY							
Cough		Sputum		Coughing blood		Wheezing	
Asthma		Bronchitis		Pneumonia		Emphysema	
Tuberculosis		Difficulty breathing		pain with breathing		shortness of breath (SOB)	
SOB lying down		SOB at night		Other			

CARDIOVASCULAR							
High blood pressure		Low blood pressure		Irregular heart beat		Palpitations	
Fast heart beat		Slow heart beat		Murmurs		Angina	
Chest pain		Swelling of limbs		Cold hands/ feet		Thrombophlebitis	
Blood clots		Varicose veins		Elevated cholesterol		Past ECG test	
Other Heart tests				Other			

BLOOD & LYMPHATIC							
Pallor (paleness)		Anemia		Slow clotting		Fatigue/weakness	
Easy bruising/bleeding		Swollen lymph nodes		Past transfusions		Other	

GASTROINTESTINAL							
Heartburn/acid reflux		Poor/change in appetite		Poor/change in thirst		Difficulty swallowing	
Indigestion		Abdominal pain/ cramps		Bloating		Gas or belching	
Bad breath		Diarrhea		Constipation		Incomplete BM	
Nausea		Vomiting		Vomiting blood		Spitting blood	
Chronic laxative use		Rectal pain		Rectal bleeding		Rectal incontinence	
Hemorrhoids		Blood in stool		Black, tarry stools		Undigested food in stool	

Mucous in stool		Hernia		Ulcer		Candida	
Intestinal worms		Liver disease		Gall bladder stones/disease		Jaundice	
Anal itching		Anal fistula		Anal fissures		Food allergies	
Other							

GENITOURINARY							
Frequent urination		Pain/burning on urination		Urgency to urinate		Urinary incontinence	
Hesitancy with urination		Waking at night to urinate		Recurrent urinary tract Infections		Blood in urine	
Kidney infection		Kidney stones		Lower back pain		Flank (side) pain	
Other							

ENDOCRINE							
Excessive urination		Excessive sweating		Heat intolerance		Cold intolerance	
Thyroid disease		Excessive thirst		Excessive hunger		Diabetes	
Hypoglycemia		Hormone Therapy		Rapid weight gain		Rapid weight loss	
Insomnia		Other					

MUSCULOSKELETAL							
Back pain		Muscle spasms/cramps		Muscle weakness		Arthritis	
Tendonitis		Jaw pain/stiffness		Joint pain/stiffness		Joint swelling	
Bursitis		Fractures		Osteoporosis		Sciatica	
Other							

NEUROLOGICAL							
Dizziness		Seizures		Fainting		Paralysis	
Stroke		Poor memory		Loss of balance		Concussion	
Numbness/Tingling		Tremors		Speech difficulty		Poor coordination	
Confusion		Dementia		Learning difficulties		Involuntary movements	
Other							

FEMALE REPRODUCTIVE							
Heavy menses		Light menses		Irregular periods		Painful periods	
Bleeding between periods		Menstrual blood clots		Vaginal discharge		Vaginal itching	
Vaginal sores		Yeast infections		Painful intercourse		Low libido	
Other sexual difficulty							
Sexually active		Birth control/Protection:					
Fibroids		Ovarian cysts/PCOS		Endometriosis		Hysterectomy	
Menopause		Difficulty conceiving		STD			
Other							

MALE REPRODUCTIVE							
Testicular masses		Testicular pain		Hernia		Prostate problems	
Discharge or sores		Low libido		Erectile dysfunction		Premature ejaculation	
Low sperm count		Other sexual difficulty		Sexually transmitted disease			
Sexually active		Use regular protection		Other			

EMOTIONAL/PSYCHOSOCIAL							
Depression		Anxiety		Mood swings or Irritability		Phobias	
Hyperactivity		Aggression		Other			
Alcohol/Drug Abuse		Addiction					