



**Triangle  
Natural  
Medicine**

**(919) 259 9320**

304 W. Weaver St, Suite 104  
Carrboro, NC 27510  
www.trianglenaturalmedicine.com

**Health History Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_ Phone (H) \_\_\_\_\_  
\_\_\_\_\_  
(city) (state) (zip) Phone (C) \_\_\_\_\_  
Email \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Gender **M** or **F** (circle)

Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
(name) (relationship) (phone)

Regular Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date & Reason for last physician visit \_\_\_\_\_  
(date) (reason)

How did you hear about Triangle Natural Medicine? \_\_\_\_\_

Have you tried Acupuncture before? **Y** or **N** (circle) Homeopathy? **Y** or **N**

If so, which, how recently, with whom, and for what? \_\_\_\_\_

***Please complete the following questions as completely as possible. If you are unsure or don't remember, your best guess is better than nothing. Indicate any areas of confusion with a question mark. Feel free to write in the margins!***

1. Please list your major complaints or concerns in order of severity and for how long you've had them:

<u>Condition</u>	<u>For how long?</u>
(1) _____	_____
(2) _____	_____
(3) _____	_____

2. Please list any foods, drugs, medications or products that you are hypersensitive or allergic to:

\_\_\_\_\_

3. List all medications (prescribed and over-the-counter), vitamins, and supplements you currently take:

\_\_\_\_\_

\_\_\_\_\_

4. Is there any chance that you may be pregnant? Y or N How far along? \_\_\_\_\_

5. Do you have any infectious diseases? Y or N If yes, please identify: \_\_\_\_\_

6. List major adulthood hospitalizations, surgeries, or illnesses in order of severity.

<u>Date</u>	<u>Treatment or Kind of Surgery</u>
(1) _____	_____
(2) _____	_____
(3) _____	_____

7. **Past Health History** (Please circle whether you have ever had any of the following.)

Abortion	Yes	No	Depression	Yes	No	HIV +	Yes	No
Alcoholism	Yes	No	Diabetes	Yes	No	Infertility	Yes	No
Allergies	Yes	No	Eating disorder	Yes	No	Mental Illness	Yes	No
Anemia	Yes	No	Endometriosis	Yes	No	Miscarriage	Yes	No
Arthritis	Yes	No	Epilepsy	Yes	No	Panic attacks	Yes	No
Asthma	Yes	No	Fibromyalgia	Yes	No	Physical Abuse	Yes	No
Autoimmune disease	Yes	No	Heart problems	Yes	No	Sexual Abuse	Yes	No
Blood disease	Yes	No	Hepatitis	Yes	No	Shingles	Yes	No
Cancer/tumor	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Chronic Fatigue	Yes	No	High Blood Pressure	Yes	No	Thyroid disorder	Yes	No
Chemical dependency	Yes	No	Low Blood Pressure	Yes	No	Other? _____		
Clotting disorder	Yes	No	High Cholesterol	Yes	No	Other? _____		

8. **Family History :**

	<u>Father</u>	<u>Mother</u>	<u>Siblings</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____
<u>Check all applicable:</u>					
Asthma/Lung disease	_____	_____	_____	_____	_____
Cancer (of what?)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

Father's father: Living? Y / N Age / Age at death: \_\_\_\_\_ Major illnesses / C.O.D.: \_\_\_\_\_

Father's mother: Living? Y / N Age / Age at death: \_\_\_\_\_ Major illnesses / C.O.D.: \_\_\_\_\_

Mother's father: Living? Y / N Age / Age at death: \_\_\_\_\_ Major illnesses / C.O.D.: \_\_\_\_\_

Mother's mother: Living? Y / N Age / Age at death: \_\_\_\_\_ Major illnesses / C.O.D.: \_\_\_\_\_

**9. Review of Symptoms:** Please check any symptoms you currently have or have had in the past year.  
 ( Please choose the one from each shaded pair that applies to you more.)

**General**

- Lower energy
- Higher energy
- Wake up tired
- Tired in afternoon
- Always tire, fatigue
- Warmer natured
- Colder natured
- Chills
- Fevers
- Weight change

**Head & Neck**

- Head injury
- Headache
- Visual disturbances
- Eye pain
- Red/inflamed eyes
- Sinus problems
- Nasal obstruction
- Nasal discharge
- Nosebleeds
- Loss of smell
- Earaches, chronic
- Ear discharge
- Hearing loss
- Ear ringing
- Chronic sore throat
- Dry mouth
- Sores on / in mouth
- Odd tastes - mouth
- Teeth problems
- Other Head & Neck problems

**Respiratory**

- Wheezing
- Allergy sensitivities
- Frequent colds
- Bronchitis, chronic
- Irregular coughing
- Shortness of breath
- Cough up phlegm
- Cough up blood
- Difficulty inhaling
- Difficulty exhaling
- Painful breathing
- Other coughing or breathing problems

**Cardiovascular**

- Chest pain
- Chest tightness
- Chest distension
- Irregular heart beat
- Heart fluttering
- Poor circulation
- Ankle swelling
- Pain below ribs
- Other heart / chest problems

**Gastrointestinal**

- Abdominal pain
- Bloating
- Belching
- Bad breath
- Heartburn / Reflux
- Stronger thirst
- Weaker thirst
- Indigestion
- Nausea/Vomiting
- Vomiting blood
- Stronger appetite
- Weaker appetite
- Gas
- Harder stool
- Looser stool
- Hemorrhoids
- Bloody stool
- Black stool
- Other GI problems

**Urinary**

- Clearer urine
- Darker urine
- Cloudy urine
- Painful urination
- Blood in urine
- Frequent UTIs
- Large quantity urine
- Small quantity urine
- Strong urine smell
- Frequent urination
- Frequent night urination
- Poor bladder control
- Urinary stopping and starting (poor flow)

- Kidney stones
- Other urine problems

**Neurological**

- Poor balance
- Recent clumsiness
- Dizziness
- Momentary loss of balance/consciousness
- Room spinning
- Numbness
- Fainting
- Poor concentration
- Convulsions/seizures
- Often lost in thought
- Extreme drowsiness
- Other neurological problems

**Musculoskeletal**

- Pain, Weakness, or Numbness in your ...*
- Fingers/hands
- Arms
- Shoulders
- Neck
- Upper back
- Ribs
- Joints
- Toes/feet
- Legs
- Hips/buttocks
- Low back pain
- Knee problems
- Whole body pain
- Whole body weakness
- Broken bones
- Other musculoskeletal problems

**Skin & Hair**

- Spontaneous sweat
- Night sweat
- Lack of sweat
- Bruise easily
- Varicose veins
- Dry, brittle hair
- Premature graying
- Dry skin

- Brittle nails
- Dark under eyes
- Acne
- Lumps under skin
- Blood not clotting
- Hair falling out
- Other skin problems

**Lifestyle & Diet**

- More healthy diet
- Less healthy diet
- Eat 3 regular meals
- Drink coffee
- Drink alcohol
- Smoke cigarettes
- Use drugs
- Enough exercise
- Not enough exercise
- Insomnia
- Dream disturbances
- Sad
- Anxiety
- Angry
- Repetitive thinking
- Forgetful
- Fearful
- Overly excitable

**Men Only**

- Erection problem
- Penis discharge
- Low sexual energy
- Prostate screening
- Other problems

**Women Only**

- Irregular cycle
- Heavier periods
- Lighter periods
- Painful periods
- Lighter blood
- Darker blood
- Blood clots
- PMS
- Vaginal discharge
- Low sexual energy
- Birth control pills
- Regular pap smears
- Other problems