HEALTH HISTORY

Maureen McKenney, O.M.D.
Path To Wellness
acupuncture & herbal medicine
6121 Lakeside Drive, Reno, NV 89511 • 775-825-1912 • FAX 775-322-1010

Name_______________________________________ Date______________________

Reason for your visit today:

Medications & Supplements: Please check the box to indicate what you are currently taking.

Antacids	Hay fever medication	Sleeping pills
Aspirin	Ibuprofen	Tranquilizers
Cold or Flu medications	Laxatives	Herbs
Diet pills	Oral contraceptives	Vitamins

Please list any medications you are currently taking that are not listed above:

____

Please list any allergies to medications you have:

____

Check the appropriate box if you have ever experienced any of the following.

Adverse reaction to medical treatment	Kidney disorder
Allergies	Low blood pressure
Anemia	Musculo-skeletal disorder
Arthritis or rheumatism	Organ transplant
Artificial heart valves or joints	Pacemaker
Bleeding disorder	Respiratory disorder
Blood disease	Rheumatic fever
Cancer or tumor	Sciatica
Chemical dependency	Seizures/Epilepsy
Diabetes	Skin disorders
Eating disorders	Special diet
Eye disorders	Stomach or intestinal disorder
Gout	Stroke
Headaches	Thyroid disorder
Heart disease	Transfusion (before March 1985)
Hemophilia	Tuberculosis
Hepatitis, Jaundice or Liver disorder	Ulcer
Herpes	Urinary tract disorder
High blood pressure	Venereal disease
Immune disorder	Other________________________

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. If you have had more than three such hospitalizations check this box . Do not include pregnancies.

1st Hospitalization____
year operation or illness hospital/city/state

2nd Hospitalization____
year operation or illness hospital/city/state

3rd Hospitalization____
year operation or illness hospital/city/state

Habits: Please mark any of the habits listed below which apply to you.

Tobacco use	Yes	No	If yes, # of cigarettes / day ________________	age started____________
Alcohol use	Yes	No	If yes, # of drinks / week _________________	age started ___________
Caffeine use	Yes	No	# of soda/day _________ # coffee /day______	# tea /day ____________
Drug use	Yes	No	Type(s)Amount / Age started: __________________________	
Do you exercise?	Yes	No	What type of exercise and how often?______________________________	

Please check the appropriate boxes below for any symptoms you have recently experienced.

HEAD & NECK
- Dizziness
- Fainting
- Neck stiffness
- Enlarged lymph glands
- Headaches
- Other_______________

EARS
- Infection
- Pain
- Ringing
- Decreased hearing
- Other________________

EYES
- Blurred vision
- Visual changes
- Spots
- Eye inflammation
- Other________________

NOSE, THROAT, & MOUTH
- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Hoarseness
- Difficulty swallowing
- Changes in taste
- Changes in smell
- Oral ulcers
- Other_____________________

SKIN
- Hives
- Rashes
- Eczema
- Itching
- Night sweating
- Excessive sweating
- Dryness
- Bruise easily
- Changes in moles or lumps
- Other__________________

RESPIRATORY
- Chronic cough
- Coughing up blood
- Coughing up phlegm
- Difficultly breathing
- Wheezing /asthma
- Frequent colds
- Other____________________

CARDIO-VASCULAR
- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Cold hands / feet
- Swelling of ankles
- Phlebitis
- Other__________________

GASTROINTESTINAL
- Indigestion
- Bloating
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Nausea
- Vomiting
- Vomiting blood
- Blood in stool or black stools
- Hemorrhoids
- Gall bladder disorder
- Recent change in weight
- Food cravings
- Other____________________

NEUROLOGICAL
- Seizures
- Tremors
- Numbness or tingling of limbs
- Paralysis
- Other_____________________

MUSCLE & JOINT
- Joint disorder
- Sore or painful muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache or pain
- Other______________________

UROGENITAL
- Pain / itching of genitalia
- Genital lesions / discharge
- Painful urination
- Frequent urination
- Excessive or scanty urination
- Blood in urine
- Diminished bladder control
- Other_______________________

FEMALE
- Frequent urinary tract infections
- Frequent vaginal infections
- Pelvic inflammatory disease
- Abnormal Pap smear
- Uterine fibroids
- Irregular periods
- Painful menstrual periods
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms
- Breast pain
- Breast lumps
- Nipple discharge
- Other________________________

First day of last menstrual cycle:
____

Date of last Pap smear:
____

Were Pap smear results normal?
Yes No____________________

Date of last mammogram:
____

Are you pregnant? Yes No
Are you nursing? Yes No
Do you use birth control?
Yes Type: __________ No

MALE
- Lumps in testicles
- Prostate problems
- Weak urinary stream
- Impotence
- Other_________________________

OTHER
- Insomnia
- Frequent dreams / nightmares
- Anxiety
- Irritability
- Forgetfulness
- Depression
- Fatigue
- Decreased libido
- Feel hot or cold
- Aversion to heat or cold
- Fever and or chills
- Thirst
- Psychiatric treatment
- Other_________________________

Please list any other symptoms not covered above:____