AURA LENZ, L.Ac.

NOTE: Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate biochemical or somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Driver's License No. & State: _____

Date of Birth: _____ Age: _____

I am: ❑ Single ❑ Married ❑ In a Partnership ❑ Separated ❑ Divorced ❑ Widowed

I live with: ❑ Myself ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends

Occupation: _____ Hours of work per week: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Are you currently under a doctor's care? _____

Doctor's Name: _____ City: _____

Are you currently seeing any other healthcare practitioners? _____

Name: _____ Type of Provider: _____

Name: _____ Type of Provider: _____

Please list all therapies you use (massage, physical therapy, etc):_____

_____

Have you received acupuncture before? _____ When? _____

How did you hear of this practice? _____

Reason for today's visit: _____

_____

Please list all medical diagnoses: _____

_____

_____

Please list all current medications (include over-the-counter and prescription medications):

Name	Dose	How Often

Name: _____ Date: _____

Please list all current supplements (include herbs, vitamins, and nutritional supplements):

Name & Brand	Dose	How Often

Please list all surgeries with year:_____

_____

_____

Please list all hospitalizations with year:_____

_____

_____

Please list all allergies and sensitivities (drugs, foods, chemicals, environmental):_____

_____

FAMILY HISTORY

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Health (Good, Fair, Poor)					
Age of Death (if deceased)					

Check all that apply:	Mother	Father	Grandparent	Sibling	Children
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Eczema					
Hay Fever					
Anemia					
Kidney Disease					
Tuberculosis					
Thyroid Disease					

Name: _____ Date: _____

Please list your health problems in order of importance to you:

1. _____
2. _____
3. _____
4. _____

Please describe a typical meal:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

To drink: _____

Do you:	**Yes**	**No**	What are your three favorite foods?
Average 8 hours sleep?			
Have a supportive relationship?			
Enjoy your work?			
Take vacations?			What three foods do you dislike the most?
Spend time outside?			
Spiritual / religious practice?			
Eat three meals per day?			
Eat out often?			How many meals per week?
Drink caffeine?			How many cups a day?
Use artificial sweeteners?			How much a day?
Drink alcohol?			How much? How often?
Use recreational drugs?			How much? How often?
Smoke cigarettes?			How much?
Did you smoke in the past?			How long? How many packs a day?
Watch television?			How many hours weekly? What time of day usually?
Read?			How many hours weekly? What time of day usually?
Use the computer?			How many hours weekly? What time of day usually?

Name: _____ Date: _____

Y= you have this now N= never had this P= had this in the past but not now

General					Broken Bones					Night Sweats			
Height					**Endocrine**	**Y**	**N**	**P**		Bags Under Eyes			
Weight					Hypothyroidism					Dark Circles Under Eyes			
Are you happy with your weight? Y/N					Hyperthyroidism					Change in hair/skin			
Were you vaccinated as a child? Y/N					Hypoglycemia					Dandruff			
Other vaccinations?					Diabetes					Dry, Brittle Hair			
					Excessive Thirst					Premature Graying			
Childhood Illnesses?(circle) Mumps					Excessive Hunger					Hair Loss			
Measles, Diphtheria, Chicken Pox,					Fatigue					Brittle Nails			
German Measles, Rheumatic Fever					Feel too hot					**Head**	**Y**	**N**	**P**
Whopping Cough, Polio					Feel too cold					Headaches			
X Rays and Special Studies List					**Immune**	**Y**	**N**	**P**		Migraines			
scans and x rays you have had. Include					Chronic Infections					Head Injury			
CAT scans, MRI scans, and other special					Frequent Infections					Foggy Headedness			
studies and Heart studies such as EKGs.					Slow Wound Healing					Heavy Headedness			
					Chronic Fatigue Syn.					Jaw/ TMJ Pain			
					Neurologic	**Y**	**N**	**P**		Facial Pain			
					Fainting					**Eyes**	**Y**	**N**	**P**
					Tremor					Glasses or Contacts			
Mental/Emotional	**Y**	**N**	**P**		Seizure					Impaired Vision			
Moods Swings					Tics					Spots in Vision			
Depression					Muscle Weakness					Floaters			
Sadness					Loss of Memory					Dryness			
Anxiety / Nervousness					Dizziness / Vertigo					Tearing			
Panic Attacks					Loss of Balance					Cataracts			
High Stress Level					Paralysis					Glaucoma			
Poor Memory					Numbness					Eye Pain			
Poor Concentration					Tingling					Red Eyes			
Other:					**Skin**	**Y**	**N**	**P**		Itchy Eyes			
Musculoskeletal	**Y**	**N**	**P**		Rash					Eye Strain			
Joint Pain					Acne					Night Blindness			
Joint Stiffness					Scars					Blurry Vision			
Arthritis					Hives					**Ears**	**Y**	**N**	**P**
Weakness					Boils					Impaired Hearing			
Back Pain					Ulcerations					Earaches			
Neck Pain					Lumps					Ear Infections			
Knee Problems					Eczema					Ringing			
Sciatica					Psoriasis					**Nose and Sinus**	**Y**	**N**	**P**
Muscle Spasm					Fungal Infection					Frequent Colds			
Limited Range/Use					Dry Skin					Sinus Pain			
Cold Limbs					Itching					Stuffiness			

Name: _____ Date: _____

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Nasal Discharge			
Loss of Smell			
Itchy Nose			
Nose Bleeds			
Hay Fever			
Mouth and Throat	**Y**	**N**	**P**
Teeth Problems			
Grinding Teeth			
Jaw Clicks			
Taste Change			
Gum Problems			
Gum Bleeding			
Mouth Sores			
Dry Mouth			
Excessive Saliva			
Sore Throats			
Hoarseness			
Difficulty Swallowing			
Neck	**Y**	**N**	**P**
Swollen Glands			
Lumps			
Goiter			
Pain / Stiffness			
Respiratory	**Y**	**N**	**P**
Asthma / Wheezing			
Difficulty Breathing			
Difficulty Inhaling			
Difficulty Exhaling			
Painful Breathing			
Shortness of Breath			
Chest Tightness			
Cough			
Spitting Up Blood			
Catch Colds Easily			
Pneumonia			
Bronchitis			
Emphysema			
Tuberculosis			
Blood Vessels	**Y**	**N**	**P**
Easy Bleeding /Bruising			
Deep Leg Pain			

Varicose Veins			
Anemia			
Cold Hands / Feet			
Thrombophlebitis			
Cardiovascular	**Y**	**N**	**P**
High Blood Pressure			
Low Blood Pressure			
Heart Disease			
Blood Clots			
Stroke			
Phlebitis			
Rheumatic Fever			
Swelling in Ankles			
Angina			
Heart Murmurs			
Irregular Heartbeat			
Palpitations			
Fainting			
Chest Pain			
Gastrointestinal	**Y**	**N**	**P**
Change in Appetite			
Nausea / Vomiting			
Vomiting Blood			
Abdominal Pain			
Ulcers			
Acid Regurgitation			
Indigestion			
Belching			
Hiccup			
Bloating			
Bad Breath			
Gallbladder Disease			
Liver Disease			
Hepatitis B or C			
Intestinal Pain			
Gas			
Diarrhea			
Constipation			
Laxative Use			
Black Stools			
Bloody Stools			

Mucous in Stools			
Itchy Anus			
Burning Anus			
Rectal Pain			
Hemorrhoids			
Anal Fissures			
Bowel Movements			
Frequency?			
Color?			
Form?			
Odor?			
Urinary	**Y**	**N**	**P**
Pain on Urination			
Frequent Urination			
Frequent Infections			
Inability to Hold Urine			
Frequency at Night			
Incomplete Urination			
Bedwetting			
Dark Urine			
Cloudy Urine			
Scanty Urine			
Dilute Urine			
Blood in Urine			
Profuse Urine			
Kidney Disease			
Kidney Stone			
Male Reproductive	**Y**	**N**	**P**
Genital Pain			
Testicular Masses			
Hernia			
Prostate Disease			
Genital Sores			
Penile Discharge			
Increased Libido			
Decreased Libido			
Erectile Dysfunction			
Premature Ejaculation			
Nocturnal Emission			
STD			
Other:			

Name: _____ Date: _____

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Female Reproductive	Y	N	P
Genital Pain			
Genital Sores			
STD			
Abnormal Pap Smear			
Vaginal Discharge			
Vaginal Odor			
Vaginal Dryness			
Endometriosis			

Ovarian Cysts			
Fibroids			
Uterine Prolapse			
Breast Lumps			
Breast Pain			
Nipple Discharge			
Increased Libido			
Decreased Libido			
Irregular Cycles			

< 25 Day Cycle			
> 35 Day Cycle			
Bleed Between Periods			
Light Bleeding			
Heavy Bleeding			
Clots			
Painful Periods			
Other:			

Women's Health History

1. Age menses began: _____
2. Date last period began: _____
3. Age of last period (if menopausal): _____
4. Date of last PAP Smear: _____
5. Length of cycle (day 1 to day 1): _____
6. Number of days of bleeding: _____
7. Do you have "PMS"? ○ Yes ○ No
8. Do you have difficult periods? ○ Yes ○ No

During your menstrual cycle, do / did you have:

9. Breast tenderness / swelling? ○ Yes ○ No
10. Headaches / migraines? ○ Yes ○ No
11. Irritability? ○ Yes ○ No
12. Depression / weepiness? ○ Yes ○ No
13. Food cravings? ○ Yes ○ No; if yes, what?

    _____
14. Bloating / water retention? ○ Yes ○ No
15. Uterine cramps? ○ Yes ○ No
16. Back pain? ○ Yes ○ No
17. Diarrhea? ○ Yes ○ No
18. Constipation? ○ Yes ○ No
19. Hot flashes? ○ Yes ○ No
20. Night sweats? ○ Yes ○ No
21. Nausea? ○ Yes ○ No
22. Other symptoms? _____
23. What method of birth control are you currently using? _____, # of years _____
24. Have you ever used: ○ birth control pill; if yes, # of years _____ ○ IUD; if yes, # of years _____ ○ birth control patch, if yes; # of years _____ ○ other: _____, # of years _____
25. Are you currently pregnant? ○ Yes ○ No
26. Number of pregnancies: _____
27. Number of live births: _____
28. What was your age at each birth? _____
29. Number of premature births: _____
30. How long did you breastfeed each baby?

    _____
31. Did you have morning sickness? ○ Yes ○ No; if yes, which weeks? _____
32. Did you have gestational diabetes? ○ Yes ○ No
33. Have you had a cesarean section? ○ Yes ○ No; if yes, how many? _____
34. Number of miscarriages: _____
35. Number of abortions: _____
36. Have you had a breast mammogram? ○ Yes ○ No; if yes, how many? _____ Any abnormal? ○ Yes ○ No

Name: _____ Date: _____

37. Have you had a breast ultrasound? ○ Yes ○ No;
    if yes, how many? _____
    Any abnormal? ○ Yes ○ No
38. Have you had a breast thermogram?
    ○ Yes ○ No; if yes, how many? _____
    Any abnormal? ○ Yes ○ No
39. Do you have breast implants? ○ Yes ○ No;
    if yes, when were they implanted? _____
40. Have you experienced menopause? ○ Yes ○ No
41. If experiencing menopausal symptoms, please list:
    _____
    _____
    _____
    _____
42. Do you use any of the following? ○ Provera
    ○ Premarin ○ Patch ○ Other hormones:
    _____

FAMILY HISTORY

Check all that apply:	Myself	Mother	Sister	Grandmother	Aunt	Daughter
Breast Cyst						
Breast Biopsy						
Uterine Fibroids						
D & C						
Ovarian Cyst						
Endometriosis						
Hysterectomy						
Oopherectomy						
Breast Cancer						
Uterine Cancer						
Ovarian Cancer						