



Manchester Acupuncture Studio, LLC

HEALTH HISTORY FOR WOMEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

- Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats
- When _____ am / pm
- Where on body _____

HOT

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Dandruff

Where on your body?:

OILY

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA

- BM: How often? _____ x / every _____ days
- Stools keep shape? ☐ Y ☐ N
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite

- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

CONSTIPATION

- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW

- ☐ Sudden energy drop
- Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak

- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy

HIGH

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____ x / week

SLEEP

- # hours per night _____
- ☐ Difficulty falling asleep
- ☐ Wake _____ x / night @ _____ am / pm
- ☐ Wake to urinate How often? _____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (color _____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

MENSES

- Age at first menses: _____
- Length of full cycle: _____ days
- Length of menses: _____ days
- Last menses start date: _____ / _____
- # of pregnancies: _____
- # of births: _____ premature _____
- # of abortions / miscarriages: _____

MENOPAUSE

- Age at last menses: _____
- Year changes began: _____
- ☐ Hot flashes _____ x / day
- ☐ Night sweats _____ x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Cramps
- ☐ Before bleeding
- ☐ First day
- ☐ During period
- ☐ Clots
- ☐ Breast tenderness

- ☐ Mood changes
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)