MIDDLE WAY
ACUPUNCTURE INSTITUTE

Please complete the health questionnaire below. All of your answers are completely confidential. The student clinic is a part of the required training for licensure in this state. Therefore, your information will be shared only by authorized faculty members and students. If you have questions, please contact Matt Van Dyke, Executive Director, at 360-336-6129.

Health History Questionnaire

Today's date_____

Name	*Telephone*	
Address	*City/State/Zip*	
Email (optional)	*Occupation*	
Emergency Contact	*Emergency contact Phone*	*Relationship*

Date of Birth _____ *Age*_____ *Height* _____ *Weight* _____
Family Physician _____ *Date of your last Physical Exam* _____
Results _____
Surgeries/Significant Trauma (include date) _____
_____
_____

Please list medications taken in the last year. Include medications, vitamins, herbs, etc. (continue on the back if needed)

_____
_____
_____

Personal Current/Past Medical History (include date)

☐ AIDS/HIV	☐ Emphysema	☐ Mumps	☐ Typhoid Fever
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker	☐ Ulcers
☐ Allergies	☐ Goiter	☐ Pleurisy	☐ Venereal Disease
☐ Appendicitis	☐ Gout	☐ Pneumonia	☐ Whooping Cough
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Other (Specify)
☐ Arthritis	☐ Herpes	☐ Rheumatic Fever	
☐ Asthma	☐ Hepatitis	☐ Scarlet Fever	
☐ Birth Trauma	☐ High Blood Pressure	☐ Seizures	
☐ Cancer	☐ Malaria	☐ Stroke	
☐ Chicken Pox	☐ Measles	☐ Tonsillectomy	
☐ Depression	☐ Migraines	☐ Thyroid Disorder	
☐ Diabetes	☐ Multiple Sclerosis	☐ Tuberculosis	

Family Medical History

☐ Allergies	☐ Cancer (type)	☐ Heart Disease	☐ Other (Specify)
☐ Arteriosclerosis	_____	☐ High Blood Pressure	_____
☐ Asthma	☐ Depression	☐ Seizures	_____
☐ Alcoholism	☐ Diabetes	☐ Stroke	

Do you exercise? (what type and how often?) _____
Do you smoke cigarettes? (YES / NO) If yes, how many a day? _____ In the past? (YES / NO) _____
Do you drink alcohol? (YES / NO) If yes, how much per? (WEEK / MONTH) _____
Do you take recreational drugs? (YES / NO) Have you in the past? (YES / NO)
How much coffee/tea/cola do you drink per day? _____ Are you pregnant? (YES / NO)
Are you under any significant stress? (YES / NO) _____