HEALTH HISTORY INVENTORY

HHI-4

Name or I.D. :____ **Date:** ___________________________

Please check an " ✘ " mark in the boxes (❑) below for those items that apply to you.

1. Health History: Have you <u>ever</u> been *diagnosed* by a licensed health care practitioner for any of the following?

❒ Tension Headaches	❒ Coronary Disorder or Heart Attack	❒ Stroke
❒ Migraine or Cluster Headaches	❒ Asthma, Bronchitis, or Emphysema	❒ Tuberculosis or Pneumonia
❒ TMJ Disorder or Jaw Pain	❒ Liver Disease or Hepatitis	❒ Brain Seizures or Epilepsy
❒ Low Back Pain or Sciatica	❒ Urinary or Bladder Disorder	❒ Concussion or Head Trauma
❒ Rheumatoid Arthritis	❒ Kidney Disorder or Stones	❒ Cancer or Tumors
❒ Osteoarthritis	❒ Gall Bladder Disorder or Stones	❒ AIDS or HIV Disease
❒ Fibromyalgia	❒ Irritable Bowel Syndrome or Colitis	❒ Multiple Sclerosis or Palsy
❒ Tremors or Tics	❒ Hypertension / High Blood Pressure	❒ Polio or Mononucleosis
❒ Tendonitis or Bursitis	❒ Hemorrhoids or Hernia	❒ Allergies or Hayfever
❒ Carpal Tunnel Syndrome	❒ Diabetes Mellitus	❒ Chronic Fatigue Syndrome
❒ Bone Fracture or Joint Sprain	❒ Thyroid Disorder	❒ Anorexia or Bulimia
❒ Radiculopathy	❒ Dysmenorrhea or Irregular Menses	❒ Attention Deficit Disorder
❒ Neuralgia	❒ Peri-Menstrual Syndrome (PMS)	❒ Panic Attacks or Phobias
❒ Peripheral Neuropathy	❒ Menopause Problems or Hot Flashes	❒ Depression or Bipolar Disorder
❒ Shingles (Herpes Zoster)	❒ Prostate or Genital Disorder	❒ Alcohol Abuse Problems
❒ Dermatitis, Eczema, or Hives	❒ Deafness or Tinnitus	❒ Substance Abuse Problems

2. Accidents: Have you <u>ever</u> been left *injured* or *impaired* by any of the following types of accidents?

❒ Automobile Accident	❒ Work-Related Accident	❒ Surgical Complication
❒ Athletic Injury	❒ Accident in Daily Living	❒ Medication Side Effect

3. Current Conditions: In the <u>past 3 months</u>, have you experienced any of the following symptoms?

❒ Frequent Headaches	❒ Chest Pain or Chest Tightness	❒ Head Congestion / Runny Nose
❒ Chronic Back Pain or Sore Back	❒ Abdominal Pain or Discomfort	❒ Dry Mouth or Dry Throat
❒ Stiff or Sore Neck and Shoulders	❒ Abdominal Distension or Bloating	❒ Sore Throats
❒ Pain in Elbows, Wrists, or Hands	❒ Large Weight Gain or Weight Loss	❒ Frequent Coughs
❒ Pain in Hips, Knees, or Feet	❒ Overeating or Binge Eating	❒ Fever or Malaise
❒ Stiff, Aching, or Swollen Joints	❒ Undereating or Poor Appetite	❒ Chills or Aversion to Cold
❒ Cold Hands or Cold Feet	❒ Craving for Sweets	❒ Nausea or Vomiting
❒ Frequent Daytime Sweating	❒ High Level of Sexual Activity	❒ Diarrhea or Loose Stools
❒ Night Sweats	❒ Low Sex Drive	❒ Constipation or Dry Stools
❒ Skin Irritation or Skin Rash	❒ Overworked or Overstressed	❒ Blurred Vision or Dry Eyes
❒ Dizziness, Fainting, or Vertigo	❒ Poor Memory or Mental Confusion	❒ Lethargy, Tiredness, or Fatigue
❒ Palpitations / Rapid Heart Beats	❒ Bored or Uninterested in Things	❒ Insomnia or Difficulty Sleeping
❒ Shortness of Breath	❒ Thoughts of Killing Your Self	❒ Disturbing Dreams
❒ Feeling Restless or Agitated	❒ Worried About Finances or Job	❒ Feeling Anxious or Afraid

4. Substances or Medications: In the <u>past 3 months</u>, did you take any of the following items on a <u>daily basis</u>?

❒ 5 or more Cigarettes	❒ Several Aspirin or Tylenol Type Pills	❒ Sleeping Pills
❒ 4 or more Cups of Coffee	❒ Prescribed Pain Reliever Medication	❒ Anti-Anxiety Medication
❒ 3 or more Glasses of Alcohol	❒ Blood Pressure Medication	❒ Anti-Depressant Medication

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PMB 2657, 8033 Sunset Blvd., Los Angeles, CA 90046, call (323) 656-2084, or download from website *www.auriculotherapy.com*