Vickery Health & Wellness
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Licensed Acupuncturist / Herbalist

PATIENT HEALTH HISTORY

Name:_____
First Middle Last

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

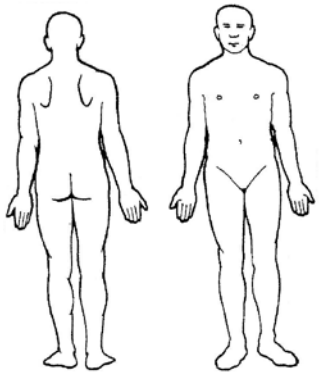
When and where did you last receive health care?_____

For what reason?_____

Has your case been referred to an attorney? Y N

Please identify the health concerns that have brought you here today in order of importance below and identify the area(s) of pain on the diagram below:

Condition	Past Treatment (if any) and how this condition affects you
a. _____	_____
b. _____	_____
c. _____	_____



If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:_____

_____

_____

Height: _____ Weight: Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____
When was this reading taken? _____

Do you have any infectious diseases? Y N

If yes, please identify:_____

_____

_____

Have you experienced any major traumas? Y N Explain:_____

_____

_____

Lifestyle and Diet:

Do you typically eat at least three meals per day? Y N If no, how many? _____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Do you drink alcohol? Y N If so, how many glasses/shots per day/week? _____

Do you use tobacco products? Y N If so, what and how often? _____

Do you use controlled substances (ie: street drugs)? Y N If so what and how often:_____

_____

Exercise routine: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Spiritual practice: _____

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation:_____

Hours/Week: _____ Do you enjoy work? Y N Why or Why not? _____

What entertainment do you enjoy and how often? This includes TV, Internet, hobbies, books etc:

_____

Family History:

Do any of your close relatives (parents, siblings, children) have, or have they had, any of the following.

	Disease	**Who, when and outcome**
☐	Cancer	_____
☐	Diabetes	_____
☐	Heart Disease	_____
☐	High Blood Pressure	_____
☐	Stroke	_____
☐	Mental Illness	_____
☐	Depression	_____
☐	Asthma / Hay Fever / Hives	_____
☐	Kidney Disease	_____
☐	Blindness or vision loss	_____
☐	Deafness or hearing loss	_____

Please indicate the age and cause of death for any close relatives:_____

General Health:

Do you believe you may be pregnant? Y / N If so, how far along are you?_____

Have you been hospitalised or had surgeries? If so, please list below:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Have you had recent, or significant, X-Ray/CAT Scan/MRI/NMR/Special Studies?

Reason	When	Reason	When
_____		_____	
_____		_____	

Please *circle* any of the following that you experience now:

Emotional:

Mood Swings
Nervousness
Mental Tension

Energy and Immunity:

Fatigue
Slow Wound Healing
Chronic Infections
Chronic Fatigue Syndrome
Hay Fever
Frequent Sore Throat

Head-Eye, Ear, Nose, Throat

Impaired Vision
Eye Pain/Strain
Glaucoma
Glasses/Contacts
Tearing/Dryness
Impaired Hearing
Ear Ringing
Earaches
Headaches not migraine
Sinus Problems
Teeth Grinding / TMJ
Nose Bleeds

Respiratory

Pneumonia
Frequent Common Colds
Difficulty Breathing
Emphysema
Pleurisy
Shortness of Breath
Persistent Cough
Tuberculosis
Asthma
Other Respiratory Problems

Cardiovascular

Heart Disease
Chest Pain
Swelling of Ankles
High Blood Pressure
Heart Murmurs
Varicose Veins
Palpitations/Fluttering

Genito-Urinary

Kidney Disease
Painful Urination
Frequent UTI
Frequent Urination
Kidney Stones
Impaired Urination
Blood in Urine
Frequent Urination at Night

Gastrointestinal

Ulcers
Changes in Appetite
Nausea/Vomiting
Epigastric Pain
Passing Gas
Heartburn
Belching
Haemorrhoids
Abdominal Pain

Musculoskeletal

Neck/Shoulder Pain
Muscle Spasms/Cramps
Arm Pain
Back Pain
Leg Pain
Joint Pain

Neurologic

Vertigo/Dizziness
Paralysis
Numbness/Tingling
Loss of Balance
Seizures/Epilepsy

Inoculations

Flu shot
Pneumonia vaccine
Tetanus, Diphtheria, Pertussis (Td, Tdap) Vaccine
Hepatitis A Vaccine
Hepatitis B Vaccine
HPV vaccine
MMR vaccine
Varicella (Chickenpox)
Meningococcal Vaccine
Shingles (Zoster) Vaccine

Male Reproductive

Sexual Difficulties
Prostrate Problems
Testicular Pain/Swelling
Penile Discharge

Female Reproductive

Irregular Cycles
Breast Lumps/Tenderness
Nipple Discharge
Heavy Flow
Vaginal Discharge
Premenstrual Problems
Clotting
Bleeding Between Cycles
Menopausal Symptoms
Difficulty Conceiving
Painful Periods
Age at first Menses:_____
Cycle length_____
Bleeding Length_____
Birth Control
Pregnancies_____
Miscarriages_____
Abortions_____
Live Births_____

Endocrine

Hypothyroid
Hypoglycemia
Hyperthyroid
Diabetes Mellitus
Night Sweats
Feeling Hot or Cold

Other (circle any that apply)

Anemia
Cancer
Rashes
Eczema/Hives
Cold Hands/Feet
Gall Bladder Disease
Liver Disease
Hepatitis B or C
Fibromyalgia
Chronic Fatigue Syndrome
Body Dysmorphic Disorder
Migraines
Gender Reassignment
Hormone therapy
HIV/AIDS
Eating Disorders
PTSD

Is there anything else we should know? _____

_____