Vickery Health & Wellness
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Licensed Acupuncturist / Herbalist

PATIENT HEALTH HISTORY

Name: _____ **Age:** _____

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.

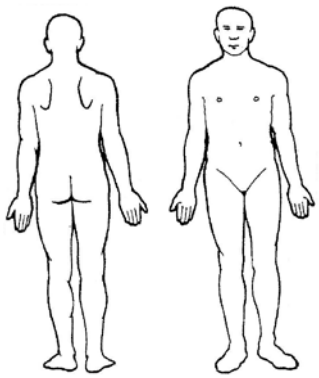
When and where did you last receive health care? _____

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	_____
☐	Other	_____

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:	**Head-Eye, Ear, Nose, Throat**	**Respiratory**
Mood Swings	Impaired Vision	Pneumonia
Nervousness	Eye Pain/Strain	Frequent Common Colds
Mental Tension	Glaucoma	Difficulty Breathing
	Glasses/Contacts	Emphysema
Energy and Immunity:	Tearing/Dryness	Pleurisy
Fatigue	Impaired Hearing	Shortness of Breath
Slow Wound Healing	Ear Ringing	Persistent Cough
Chronic Infections	Earaches	Tuberculosis
Chronic Fatigue Syndrome	Headaches not migraine	Asthma
Hay Fever	Migraines	Other Respiratory Problems
Frequent Sore Throat	Sinus Problems	
Rashes	Teeth Grinding / TMJ	
Eczema/Hives	Nose Bleeds	
HIV/AIDS		

Cardiovascular

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

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

Male Reproductive

Sexual Difficulties
Prostrate Problems
Testicular Pain/Swelling
Penile Discharge

Endocrine

Hypothyroid
Hypoglycaemia
Hyperthyroid
Diabetes Mellitus
Night Sweats
Feeling Hot or Cold

Neurologic

Vertigo/Dizziness
Paralysis
Numbness/Tingling
Loss of Balance
Seizures/Epilepsy
Cold Hands/Feet

Female Reproductive

Irregular Cycles
Breast Lumps/Tenderness
Nipple Discharge
Heavy Flow
Vaginal Discharge
Premenstrual Problems
Clotting
Bleeding Between Cycles
Menopausal Symptoms
Difficulty Conceiving
Hormone therapy
Painful Periods

Other (circle any that apply)

Fibromyalgia
Cancer
PTSD
Hepatitis B or C
Gall Bladder Disease
Liver Disease
Gender Reassignment
Body Dysmorphic Disorder
Eating Disorders

Inoculations	**Menstrual History**
Flu shot	Age at first Menses:_____
Pneumonia vaccine	Cycle length_____
Tetanus, Diphtheria, Pertussis (Td, Tdap) Vaccine	Bleeding Length_____
Hepatitis A Vaccine	Birth Control
Hepatitis B Vaccine	# Pregnancies_____
HPV vaccine	# Miscarriages_____
MMR vaccine	# Abortions_____
Varicella (Chickenpox)	# Live Births_____
Meningococcal Vaccine	
Shingles (Zoster) Vaccine	

Is there anything else we should know? _____

_____