

VICKERY HEALTH & WELLNESS

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PATIENT HEALTH HISTORY

Name: _____ **Age:** _____

Traditional East Asian Medicine, of which Acupuncture is only one component, views the body as a whole. Regardless of why you have been referred to this office for care, Dr Vickery would like to know more about your overall health to create a complete plan of care. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

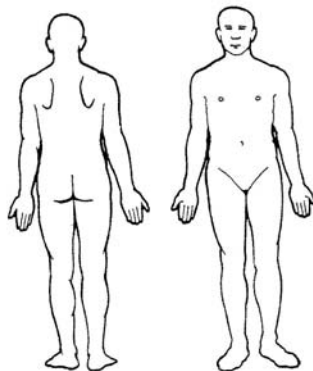
When and where did you last receive health care? _____

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.

<u>Disease</u>	<u>Who, when and outcome</u>
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Asthma / Hay Fever / Hives	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Blindness or vision loss	_____
<input type="checkbox"/> Deafness or hearing loss	_____
<input type="checkbox"/> 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:

- Mood Swings
- Nervousness
- Mental Tension

Head-Eye, Ear, Nose, Throat

- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses/Contacts
- Tearing/Dryness
- Impaired Hearing
- Ear Ringing
- Earaches
- Headaches not migraine
- Migraines
- 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

Energy and Immunity:

- Fatigue
- Slow Wound Healing
- Chronic Infections
- Chronic Fatigue Syndrome
- Hay Fever
- Frequent Sore Throat
- Rashes
- Eczema/Hives
- HIV/AIDS

Cardiovascular

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

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
 Cold Hands/Feet

Genito-Urinary

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

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
 Hormone therapy
 Painful Periods

Gastrointestinal

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

Endocrine

Hypothyroid
 Hypoglycaemia
 Hyperthyroid
 Diabetes Mellitus
 Night Sweats
 Feeling Hot or Cold

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

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

Menstrual History

Age at first Menses: _____
Cycle length _____
Bleeding Length _____
Birth Control
Pregnancies _____
Miscarriages _____
Abortions _____
Live Births _____

Is there anything else we should know? _____
