VICKERY HEALTH & WELLNESS
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Licensed Acupuncturist / Herbalist

# 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.

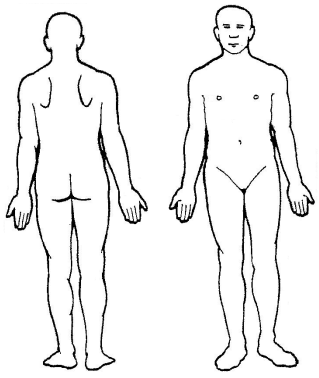
When and where did you last receive health care? _____

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 (physical or emotional)? 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 any CBD or cannabis products (including edibles)? Y N _____

Do you use controlled substances (ie: street drugs)? Y N What & 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

_____ _____

_____ _____

_____ _____

Do you have any scars, surgical or other?
Please list when & where located:

_____

_____

_____

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
Anxiety

**Energy and Immunity:**
Fatigue
Slow Wound Healing
Chronic Infections
Chronic Fatigue Syndrome
Hay Fever
Frequent Sore Throat
Rashes
Eczema/Hives
HIV/AIDS

**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

**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**

COVID vaccine

Flu vaccine

Pneumonia vaccine

Shingles (Zoster) Vaccine

HPV vaccine

Varicella (Chickenpox)

Meningococcal Vaccine

Hepatitis A Vaccine

Hepatitis B Vaccine

MMR vaccine

Tetanus, Diphtheria, Pertussis (Td, Tdap) Vaccine

Vaccine not listed above: _____

**Menstrual History**

Age at first Menses: _____

Cycle length (from Day 1 to Day 1) _____

Bleeding Length (how many days do you bleed?) _____

Birth Control? Y / N Which one? _____

# Pregnancies_____

# Miscarriages_____

# Abortions_____

# Live Births_____

Is there anything else we should know? _____

_____

_____

_____

_____

_____

_____