DRAGONFLY
ORIENTAL MEDICINE

Health History

Name_____Date_____
Reason for Visit:_____
_____
_____

Date Symptoms first appeared or Date of Injury_____
Is condition due to injury arising from your employment? Y N Motor Vehicle Accident? Y N

Physician_____Phone_____
Date of last physical exam_____

Age_____Date of Birth_____Height_____Weight_____
Blood Pressure_____Cholesterol_____
Medications/Drugs/Herbs/Vitamins you are currently taking (if this list is extensive, please list on a separate piece of paper)_____
_____
_____
_____
Surgeries (include dates)_____
_____
._____
Any major illnesses, traumas, injuries, scars, broken bones, concussions, etc. at any time in your life_____
_____
_____
_____
Occupation_____Work Stress Factors_____

Medical History:

❒ Allergies	❒ High Blood Pressure	❒Heart Disease
❒ Cancer	❒ Seizures	❒Autoimmune Disease
❒ Diabetes	❒ Hepatitis ____	❒ HIV
❒ Thyroid Disease	❒ High Cholesterol	❒ PTSD

Married/Divorced/Single/Widowed Who do you live with_____
Number of Children_____ How old are they?

Please underline any symptoms that you have or write the information:

General
How is your energy level?
Do you run hot or cold?
Just hands and/or feet always cold?
Sleep: great/ insomnia/ restless/ up from 1-3am
Depression
Anxiety
Difficulty concentrating
Anger
Fear
Ear infections as a child?
Food cravings? salty/ sweet
Fevers
Perspiration when not exercising

Pain/Musculoskeletal
Where is your pain?_____
Spasms
Swelling
Disc issues
Sciatica

Skin
Eczema/rashes/itching
Acne
Easy bruising
Dry skin
Hives/allergies

Head/Eyes/Ears/Nose/Throat
Dizzy spells/fainting/vertigo
Frequent headaches how often? where?
Migraines
Eyes red/itchy/dry
Difficulty hearing
Tinnitus/ringing in ears
Sinus congestion/infections

Gastro-Intestinal
Difficulty swallowing/feels like something stuck in throat
Nausea/vomiting
Belching/gas/bloating
Acid reflux/GERD
Constipation/Diarrhea/Both
Hemorrhoids/blood in stool
Appetite not at all/ not in a.m./ excessive
Significant weight change gain/loss
Food allergies
Sleepy after meals

Cardiovascular
Palpitations
Tight around chest/pressure/pain
High or low blood pressure
Varicose veins
Pacemaker
Swelling of ankles/feet
Blood clots

Respiratory
Shortness of Breath/can't take deep breath
Asthma/ wheezing
Cough dry/ phlegmy/ chronic/ acute
Frequent colds

Genito-Urinary
Frequent urination
Pain/burning with urination
Incontinence
Blood in urine
Bladder/Kidney infections/Stones

For Men:
Prostate issues
Vasectomy
Infertility
Lumps or swelling on testicles

For Women:
Age at first menstrual period_____
Date of last menstrual period_____
Date of last PAP smear/Gyn exam_____
Number of pregnancies_____
Irregular menses
Heavy bleeding with period
Cramps with period
PMS/ moodiness/ breast tenderness/ bloating
Breast lumps
Endometriosis
Uterine fibroids
Ovarian cysts
Uterine prolapse
Perimenopausal issues
Menopausal issues
Hot flashes
Infertility