Fractal Dragon Acupuncture & Oriental Medicine, LLC

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Patient Information

Your Name: _____ **Today's Date:** _____

For Women Only:

Please check if you have had any of the following:

Past	Now	Symptom	Past	Now	Symptom
☐	☐	Abdominal pain or cramps w/menses	☐	☐	Hot Flashes
☐	☐	Abnormal PAP smear	☐	☐	Irregular Menstruation
☐	☐	Abortion	☐	☐	I.U.D.
☐	☐	Amenorrhea (No menses)	☐	☐	Menopause
☐	☐	Back pain with menstruation	☐	☐	Miscarriage
☐	☐	Birth Control Pills	☐	☐	Premenstrual Tension / Syndrome
☐	☐	Bleeding between periods	☐	☐	Pregnancy
☐	☐	Bleeding during or post-intercourse	☐	☐	Scanty Bleeding with period
☐	☐	Bloating before periods	☐	☐	Tubal Ligation
☐	☐	Blood discharge from nipples	☐	☐	Sick or weak with menstruation
☐	☐	Breast Lumps	☐	☐	Vaginal Discharge
☐	☐	Heavy bleeding with period	☐	☐	Vaginal Dryness or Itching

Age that you began menses? _____ **Number of births you have had?** _____

Number of days between periods: _____ **Ages of your children?** _____

Date of last period: _____ **Birth Control and Method?** _____

Age you began menopause? _____