Olympia Dreszer, ND

Information Confidential: PLEASE PRINT Date: _____

Name: _____ Age: ____ Sex: M/F _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

Telephone: _____ Ext: _____ Evening Phone: _____

Referred by: _____ Physician: _____

Have you ever had an acupuncture facial? _____ Do you bruise easily? _____

What medications are you taking? _____

For what conditions? _____

What vitamins are you taking? _____

Blood Type: _____

Medical History: (check all that apply)

- AIDS/HIV
- Allergies: To what?
- Asthma
- Cancer
- Emphysema
- Hepatitis A/B/C
- Lyme Diseases
- Multiple sclerosis
- Polio
- Scarlet fever
- Tuberculosis
- Lymph nodes removed
- Other
- Alcoholism
- Allergies to cosmetics:
- Birth trauma
- Diabetes
- Heart Diseases
- Herpes
- Mitral valve
- Pacemaker
- Rheumatic fever
- Seizures
- Latex allergy
- Vaccine veins
- Bruise easily

Injuries, Surgeries, Major Illness:

Please provide details: _____

When (dates) _____

Diet:

Breakfast	Lunch	Dinner	Snacks

Food Cravings? _____

Food Intolerances? _____

How many glasses/cups do you drink each day of the following?

Water _____ Soda _____ Coffee _____ Tea _____
Alcohol _____

How many do you consume (servings perday/week)?

Meat _____ Sugar/Sweets _____ Diary/Milk/Cheese/Yogurt _____

Do you perspire during the day? _____

Do you perspire at night? _____

Are you always thirsty? _____

Do you prefer _____Hot or _____Cold drinks

Taste Preferences (Indicate 1 -5; 1=Most liked; 5=Disliked)

Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Gastrointestinal

Do you have or have you had? (check all that apply)

Belching _____ Nausea _____ Vomiting _____ Ulcers _____ Bloating _____
Indigestion _____ Hernia _____ Hemorrhoids _____ Acid reflux _____ Bowel
Movements How often? _____ day/week Irregularity _____ Constipation _____
Diarrhea _____ Gas _____ Burning _____

Exercise and Energy

What kind of exercise do you engage in? _____ How often? _____

How is your general energy level? _____

Emotions and Sleep

Do you have or have had? (check all that apply)

Panic attacks _____ Depression _____ Anxiety _____ Nerves _____ Fear _____
Poor Memory _____ Difficulty concentrating _____

Do you take antidepressants? _____ What kind? _____

Do you take sleeping pills? _____ What kind? _____

Do you have? (check all that apply)

Difficulty falling asleep _____ Restless _____ Disturbed sleep _____ Waking up at _____ am/pm

Urination How often? _____ times per day Color: _____

Do you have or have you had? (check all that apply)

Frequent urination _____ Incontinence _____ Burning _____ Bladder infections _____

GYN

Are you still menstruating? _____

Irregular Menses _____ Heavy flow _____ Light flow _____ No flow _____ Blood Clots _____

PMS _____ Painful Periods _____ Uterine fibroids _____ Cystic breasts _____

Are you perimenopausal? _____ Symptoms _____

Are you menopausal? _____ Symptoms _____

Respiratory, ENT and Head

Do you smoke? No _____ Yes _____ Times/day for _____ years

Do you have or have you had? (check all that apply)

Frequent colds _____ Asthma _____ Dizziness _____ Cold sores _____ Bleeding Gums _____

Dry mouth _____ Ear pain _____ Ringing in ears _____ Clogged Popping _____ Frequent Headache _____ Migraine _____

Cardiovascular

Do you have or have had? (check all that apply)

Palpitations _____ Varicose veins _____ Spider veins _____ Cold hands/ feet_____ mitral valve _____

Poor circulation _____ Irregular heart beat _____

Skin and Hair

Do you have or have had? (check al that apply)

Dry skin _____ Skin rashes _____ Itching _____ Acne _____ Eczema _____

Hives _____ Hair loss _____

Are there any additional health conditions that I should be informed of?

_____
_____
_____

Thank You!!!