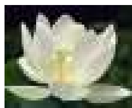

White Lotus Health Center
Return Office Visit Form

Name: Date:

Please share your goals for this office visit. Acute Care ☐ Wellness Care ☐ Other ☐

Please **check any category that applies** to you, **fill in any relevant details** and **leave blank** any category where you have no symptoms.

Since my last visit, my condition has: ☐ Improved ☐ Worsened ☐ Stayed the Same

Presently, are you aware of having a cold/flu or any other infection? ☐ Yes ☐ No

Are you having any allergy symptoms? ☐ Yes ☐ No If so, from what?

Please list prescription drugs you are currently taking:

Click on all check-boxes that apply to you.

EYES	**EARS**	**NOSE**	**THROAT**	**TEETH**	**HEADACHE**
☐ Dry ☐ Itch ☐ Blurry Vision ☐ Red ☐ Yellow ☐ Watery ☐ Floaters Pain 1-10:	☐ Ringing ☐ high pitch or ☐ low roar ☐ Fluid/Filled Pain 1-10:	☐ Bleeding ☐ Stuffy ☐ Dry ☐ Runny ☐ Phlegm ☐ yellow ☐ green Pain 1-10:	☐ Hoarse ☐ Sore ☐ Swollen ☐ Sensation of lump in throat	☐ Sensitive to: ☐ hot ☐ cold ☐ Bleeding gums with brushing Pain 1-10:	☐ Top ☐ Side ☐ Front ☐ Back ☐ Daily ☐ Weekly ☐ Monthly ☐ Throbbing ☐ Stabbing ☐ Achy Pain 1-10:

BOWELS	**DIGESTION**	**HEART/CHEST**	**SLEEP**
Movements per day: ☐ Loose ☐ Formed ☐ Diarrhea ☐ Constipation ☐ Stink ☐ Float ☐ Need to Push ☐ Hemorrhoids ☐ Smelly	☐ Nausea ☐ Gas ☐ Bloating ☐ Heartburn ☐ Belching **APPETITE** ☐ Poor ☐ Excessive ☐ Variable ☐ Good ☐ None	Pain 1-10: ☐ Palpitations (☐ am ☐ pm) ☐ Difficulty breathing ☐ Pressure ☐ Shortness of breath ☐ Cough (☐ Dry or ☐ Productive) ☐ Phlegm in chest ☐ yellow ☐ green ☐ gray ☐ clear ☐ red **SWEAT** ☐ Night-time ☐ Day-time ☐ Fever ☐ Hot flashes ☐ location:	Sleep is: ☐ Heavy ☐ Light Dreams are: ☐ Pleasant ☐ Stressful ☐ Don't remember Go to bed at: Wake up at: Hours of sleep at night: ☐ Difficulty falling asleep ☐ Snore ☐ toss & turn ☐ Sleep walk ☐ Wake up w/difficulty going back to sleep ☐ Wake up a.m. ☐ refreshed ☐ tired ☐ Hard to wake up in a.m.

URINATION	**DIZZINESS**	**EMOTIONS** - Indicate most prominent ones:
☐ Weak stream ☐ Dribbling ☐ Wake up to Urinate: times per night? ☐ Urgency ☐ Leakage ☐ Clear ☐ Dark yellow ☐ Strong odor	☐ Whirly dizzy/room spins ☐ Blackout ☐ Need to stabilize if I stand up too quickly	☐ Fear ☐ Anger ☐ Sadness ☐ Worry ☐ Anxiety ☐ Impatience ☐ Irritability ☐ Laugh too easily ☐ Apathy ☐ Rage ☐ Spaced out ☐ Other:

MENSES: This is day of my cycle. My cycle began on . My period comes every days.
My last period came - . I usually bleed for days. Bleeding is - ☐ Profuse ☐ Normal ☐ Scanty
Color: ☐ Pink ☐ Bright red ☐ Red ☐ Dark Red ☐ Brown ☐ Black I get PMS days before my period.
Consistency: ☐ Mucousy ☐ Watery ☐ Liquid paint ☐ Thick ☐ Clots/lumps
Breasts: ☐ Tender ☐ Lumps ☐ Swelling Pain 1-10: ☐ Cramps Where: When:
Pain: Where: Pain 1-10: Better with: Worse with:

ENERGY Level 1-10: ☐ Fluctuates	Temperature: Tends toward:	Well Being: Stress Level 1-10:
☐ Fatigue in - ☐ morning, &/or ☐ afternoon, &/or ☐ evening	☐ Hot or ☐ Cold ☐ Fever – degrees ☐ Hot flashes ☐ Cold hands/feet	Hours of exercise per week: Number of daily meal:

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