Diagnosis: Challenging Cases with Dr. Nan Lu, OMD

Complete this form and email it to:
programs@tcmworld.org in order for your case to be considered.

GRAND MASTER NAN LU

Practitioner's Name_____Practitioner's Email_____

Patient's Age_____Patient's Gender: Male____Female____Other____

As the practitioner, I am willing to present my case live with Dr. Nan Lu: Yes____ No____

Please ☑ "Yes" when applicable, put a check mark, or fill in the blanks below:

I. Patient Main Complaint (Only 2):

II. Patient Symptoms:

1. Fatigue	yes	10. Loss of Appetite	yes	19. Depression	yes
2. Dizziness	yes	11. Abdominal Distension	yes	20. Anxiety	yes
3. Palpitations	yes	12. Headache	yes	21. Nervousness	yes
4. Hot Flashes	yes	13. Stomachache	yes	22. Angry Mood	yes
5. Perspire a lot	yes	14. Diarrhea	yes	23. Nightmares	yes
6. Shortness of Breath	yes	15. Constipation	yes	24. Loss of Sexual Interest	yes
7. Chest Pain	yes	16. Skin Rash	yes	25. Forgetting Information	yes
8. Back Pain	yes	17. Dry Mouth	yes	26. Frequent Urination	yes
9. Muscle Tension	yes	18. Insomnia	yes	27. Cold Hands & Feet	yes

III. Additional Information:

1. Heart Disease: ___ heart attack ___ arrhythmia ___ angina medications:_____
2. Allergies: ___ wheat ___ nuts ___ fruit ___ seafood ___ dairy
   ___ pollen ___ fall ___ spring ___ all year
3. High Blood Pressure: ___ how long ___ special diet medications:_____
4. Diabetes: ___ how long ___ special diet medications:_____
5. High Cholesterol: ___ how long ___ special diet medications:_____
6. Organs removed: ___ which ones _____ when _____
7. Frozen Shoulder: ___ when _____

IV. For women only:

Menstrual Cramps: ___ none ___ before ___ during ___ after
Pain Intensity (10 being the worst): 1 2 3 4 5 6 7 8 9 10
Menstrual Disorders: ___ early ___ late ___ irregular ___ short cycle ___ long cycle
Other Symptoms: ___ diarrhea ___ constipation ___ headache ___ bloating
Vaginal Discharge: ___ none ___ white ___ yellow ___ heavy
Flow (quantity): ___ light ___ heavy ___ # days of flow ___ clots
Are you pregnant? ___ no ___ yes ___ which month

V. Medications:

Name _____ How long_____ Condition_____
Name _____ How long_____ Condition_____
Name _____ How long_____ Condition_____
Name _____ How long_____ Condition_____
Name _____ How long_____ Condition_____

VI. Please list and date any surgeries:

Procedure _____Date_____ Procedure_____ Date_____
Procedure_____ Date_____ Procedure_____ Date_____