General Information

Name (First, Middle, Last) _____

Age _____ Date of Birth _____ Sex _____

Phone _____ Email _____

Partner's Name _____

Home Address _____

City _____ State _____ Zip Code _____

Occupation _____

Employed By _____

Employer Address _____

Employer City _____

Employer State _____ Zip Code _____ Business Phone _____

Social Security Number _____

Emergency Contact and Relationship _____

Emergency Contact Phone _____

I understand that I should seek a physician's evaluation for the condition for which I am requesting consultation. The diagnosis and treatment plan I will be given is based upon Traditional Chinese Medicine principles and natural treatment only and does not constitute a Western medical diagnosis. I understand that I am not to rely on the Traditional Chinese Medical diagnosis and treatment as the sole remedy for the condition for which I am seeking treatment. I understand that if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western medical doctor. Further, if I am concurrently undergoing Western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

Signature _____ **Date** _____

Fertility History

Age at which menses began _____

Have your cycles changed since they began? _____

How? _____

_____

Do you ovulate on your own? _____ On what day of your cycle? _____

Do you experience fertile cervical fluids? _____

Do you experience ovulation pain? _____

Do your breasts get tender at/during ovulation? _____

Do you get premenstrual low back pain? _____

Do your bowel movements become loose at the beginning of your period? _____

Are your periods painful? _____

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? (Light, Normal, or Heavy)

What color is the blood? (Light Red, Red, Dark Red, Purple, Brown, or Black)

Is there clotting? _____

Do you have premenstrual tension? _____

Does your face break out before or during your period? _____

Do you experience premenstrual headaches? _____

Do your breasts become tender premenstrually? _____

Do you spot between periods? _____

Are your menstrual cycles spaced irregularly? _____

How many days are there from one period to the next? _____

Date of last menstrual period? _____

Have you had fertility treatments? _____

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medications to help you ovulate? _____

When? _____ How long? _____

Have your fallopian tubes been evaluated medically? _____

What are the results? _____

Have you had any tubal operations? _____

Have you had hormone laboratory tests performed? _____

What are the results? _____

Do you have a single partner with whom you have been trying to conceive? _____

How long have you been married or living together? _____

Has he had a fertility workup? _____

What are the results? _____

Is your partner supportive of your wish to conceive? _____

How many pregnancies have you had? Number _____ Years _____

How many children do you have? Number _____ Years _____

How many abortions have you had? Number _____ Years _____

How many miscarriages have you had? Number _____ Years _____

How many times has a D&C been performed? Number _____ Years _____

Have you ever had an abnormal pap smear? _____

Have you ever had a cervical biopsy, operation, cauterization, or conization? _____

Have you ever had a venereal disease? _____

Have you ever been diagnosed with a chlamydial infection? _____

Do you get yeast infections regularly? _____

Do you have chronic vaginal discharge? _____

Do you have any sores on your genitals? _____

Have you ever had pelvic inflammatory disease? _____

Were you treated for it? _____

How? _____

Date of last pap smear? _____

Have you ever been diagnosed with uterine fibroids or polyps? _____

Have you ever been diagnosed with endometriosis? _____

Have you ever been diagnosed with pelvic adhesions? _____

Have you ever been diagnosed with any pelvic abnormalities? _____

How heavy is your sexual energy? (Low, Normal, High)

Do you douche regularly? _____ With what? _____

Do you use vaginal lubricants? _____

Are you more than 20% over your ideal body weight? _____

Do you have a stressful occupation? _____

Do you exercise regularly? _____

Do you have excessive facial hair? _____

Do you have excessively oily skin? _____

Have you experienced excessive loss of head hair? _____

Have you noticed discharge from your nipples? _____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?_____

Have you been exposed to any known environmental toxins or hormones? _____

Are you presently taking steroids? _____

Have you taken oral contraceptives? _____

When? _____ How long? _____

Have you ever had an IUD? _____

When? _____ How long? _____

Have you taken other forms of hormonal birth control? _____

When? _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? _____

What was it? _____

Have you taken any medications for gynecological conditions other than contraceptive? (Please List Below)

1. Medication _____ How long? _____

Reason? _____

2. Medication _____ How long? _____

Reason? _____

3. Medication _____ How long? _____

Reason? _____

4. Medication _____ How long? _____

Reason? _____

5. Medication _____ How long? _____

Reason? _____

Medical History

Major Health Complaint/Problem? _____

_____

How did this condition develop? _____

How long has this condition persisted? _____

Is there anything that makes it better? _____

Is there anything that makes it worse? _____

Have you ever received treatment for this condition? _____

If yes, when and where? _____

By whom? _____

What was the diagnosis? _____

What kind of treatment did you receive? _____

What were the results of the treatment? _____

List any substances you are allergic to: _____

_____

List any medications you are currently taking (<u>other than</u> the medications listed in the Fertility History form):

1. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

2. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

3. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

4. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

5. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

6. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

7. Medicine _____ Strength? _____

   Dosage? _____ How Long? _____

List any major surgeries you have had:

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Significant Trauma (Auto accidents, falls, etc.?) _____

Significant illnesses:

_____ Arthritis
_____ Asthma
_____ Autoimmune Disease
_____ AIDS
_____ Cancer
_____ Connective Tissue Disease
_____ Diabetes
_____ Gallstones
_____ Heart Disease
_____ Hepatitis
_____ Hypertension
_____ Rheumatic Fever
_____ Ruptured Appendix
_____ Seizures
_____ Thyroid Disease
_____ Venereal Disease
_____ Kidney Stones

Health History

Please indicate any symptoms you have or have had in the past year.

General

___ Chills
___ Low energy
___ Dizziness
___ Allergies
___ Fatigue
___ Fevers
___ Excess thirst
___ Insomnia
___ Nervousness
___ Numbness
___ Sweat spontaneously
___ Night sweating
___ Lack of sweating
___ Weight loss
___ Weight gain
___ Aversion to heat
___ Aversion to cold

Head & Neck

___ Blurred vision
___ Heaviness in the head
___ Headache
___ Phlegm in throat

Head and Neck cont'd

___ Cataract
___ Double vision
___ Earache
___ Ear discharge
___ Eye pain/strain
___ Corrected vision
___ Nasal obstruction
___ Nasal discharge
___ Loss of sense of smell
___ Hearing loss
___ Hoarseness
___ Nosebleeds
___ Recurrent sore throat
___ Red/inflamed eye
___ Ringing in ears
___ Sinus problems
___ Sore on lips
___ Sores on tongue
___ Taste change
___ Teeth problems
___ Vision – see halos

Respiratory

___ Asthma
___ Hay fever
___ Persistent cough
___ Coughing blood
___ Shortness of breath
___ Recurrent bronchitis
___ Phlegm production
___ Difficulty inhaling
___ Difficulty exhaling

Cardiovascular

___ Chest pain
___ High blood pressure
___ Low blood pressure
___ Irregular heart beat
___ Poor circulation
___ Swelling of ankles
___ Varicose veins
___ Hypochondriac pain
___ Distention in chest or hypochondrium

Gastrointestinal

___ Abdominal pain
___ Bloating
___ Belching
___ Gas
___ Constipation
___ Diarrhea/loose stools
___ Bloody stools
___ Difficulty swallowing
___ Poor appetite
___ Heartburn/reflux
___ Hemorrhoids
___ Indigestion
___ Stomachache
___ Nausea
___ Vomiting
___ Vomiting blood

Diet & Lifestyle

___ Vegetarian
___ Healthy diet
___ Eat much fried foods
___ Eat much meat
___ Smoke cigarettes
___ Drink alcohol
___ Use drugs
___ Eat a lot of sweets
___ Take melatonin
___ Take steroids
___ Exercise regularly

Weight

___ Underweight
___ Normal for height
___ Overweight
___ Very overweight

Genitourinary

___ Dilute urine
___ Dark urine
___ Blood in urine
___ Cloudy urine
___ Burning on urination
___ Scanty urine
___ Profuse urine
___ Frequent urination
___ Poor bladder control
___ Urgency to urinate

Musculosketal Pain

Weakness or numbness in:

___ Arms
___ Feet
___ Hands
___ Joints
___ Legs
___ Hips
___ Neck
___ Shoulders
___ Pain all over
___ Cold limbs
___ Knee problems
___ Low back pain
___ All over weakness
___ Lack of strength
___ Broken bones

Skin

___ Thick skin
___ Thin skin
___ Broken blood vessels
___ Blood not clotting
___ Bruise easily
___ Discoloration
___ Dark circles around eyes
___ Bags under eyes
___ Lumps in groin

Skin cont'd

___ Lumps underarm
___ Dry skin
___ Acne
___ Brittle nails
___ Premature gray hair
___ Dry brittle hair
___ Hair falling out

Neurological

___ Fainting
___ Convulsions
___ Handwriting change
___ Paralysis
___ Stroke
___ Seizures
___ Tremor
___ Recent clumsiness
___ Drowsiness
___ Vertigo

Emotional

___ Insomnia
___ Irritability
___ Often feel angry
___ Troubling dreams
___ Cry uncontrollably
___ Feel sad a lot
___ Forgetful
___ Mind not clear
___ Anxiety
___ Much fear
___ Unrestrained joy
___ Terrors
___ Difficulty expressing emotions

Women Only

___ Abnormal pap smear

___ Bleed between periods

___ Irregular periods

___ Heavy periods

___ <25 day cycle (less)

___ >25 day cycle (greater)

___ Endometriosis

___ Painful periods

___ Premenstrual tension

___ Breast lumps

___ Contraceptives

___ Sore on genitalia

___ Low sexual energy

___ Vaginal discharges

___ Menopausal

___ Uterine prolapse

___ Facial Hair

___ Loss of body hair

___ May be pregnant