Stillwater Acupuncture Clinic

Fertility * Women's Health * General Wellness

First Name: **Last Name:** **Today's Date:**

_____

Date of Birth: _____ **Age**: _____

Marital Status: *(please circle)*

Single Married Life Partner Divorced Widowed

Street Address: _____

_____

City/State/Zip: _____

Permission to leave a message?

Home Phone: _____ Yes No

Work Phone: _____ Yes No

Cell Phone: _____ Yes No

Email Address: _____ Yes No

How did you hear about Stillwater Acupuncture Clinic?
(If Internet, which site or search engine?)

_____

_____

In Case of Emergency Contact: _____

Relationship and Phone Number: _____

Primary Health Concern:

Other Health Concern:

Your Medical History (Please list major events and dates that they occurred. Please include marriages, births, deaths, divorce, accidents, major illness, surgery, job changes, miscarriages, and anything else you feel has greatly impacted your life or health)

Were you breastfed as a baby? Yes No **For how long?** _____

List any medications (prescription and over-the-counter), vitamins and/or supplements that you are taking:

Supplement/Medication	**Reason you are taking:**

Circle any of the following conditions that you are experiencing:

- Diabetes
- Parasites
- Asthma
- Lyme Disease
- Venereal Disease
- Thyroid Problems
- Herpes
- Anemia
- Inflammatory Bowel Disease
- Heart Disease
- Nervous illness
- Allergies
- Seizures
- Mononucleosis
- Chronic Fatigue
- COPD
- Hepatitis
- Bleeding/Clotting Tendency
- High Blood Pressure
- Addiction/Alcoholism
- Osteoporosis
- Cancer
- Autoimmune illness
- Fibromyalgia
- Rheumatic Fever
- Kidney Disease
- Stroke
- Arthritis
- Ulcers
- Gall Stones
- Tuberculosis
- Anxiety/Depression
- HIV/AIDS
- Kidney stones

Other conditions not listed above: _____

_____

When is the last time you had your Vitamin D level checked? _____

When is the last time you had blood work? _____

What did the blood work indicate? _____

Do you crave any particular foods? Yes No

Which ones: _____

When do you typically crave them? _____

List any foods that you avoid due to allergies, sensitivities, religious or other beliefs:

_____

Do you use:	Now	Past	Frequency	Never
Tobacco				
Alcohol				
Caffeine				
Soft Drinks				

Do you exercise: Yes No Number of times per week**:** _____

Type of Exercise: _____

Your current weight _____

Your ideal weight: _____

Have you gained or lost more than 10 pounds in the past year? Yes No

Please list all areas of pain below:

_____

_____

_____

_____

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty Profuse Dribbling

Number of times you get up per night to urinate: _____

Bowel Movements: Frequency: _____

Stools:	Undigested food		Blood	Mucous
Consistency:	Well-formed	Hard	Loose	Alternates

Lifestyle

Please list three cleaning products that are typically used in your home (e.g. Windex, Tilex, Clorox)

1. _____
2. _____
3. _____

Do you use chemical fertilizers on your lawn? Yes No

Type of water you drink? Tap Britta Reverse Osmosis Bottled Other

On a scale of 1-10, how stressed do you feel? 10= extremely stressed, 1= not stressed at all _____

Do you practice yoga? Yes No

Do you meditate? Yes No

On a scale of 1-10, how would you rate your relationship with your partner? _____

10= excellent, 1= Very unfulfilling

Women Only:

At what age did you first get your period? _____ **Date of last menstrual cycle?** _____

Are you currently on the Pill? Yes No

Have you ever been on the Pill? Yes No **How long?** _____

What type of birth control do you use? _____

Are you pregnant now? Yes No

Number of days from the start of one period to the next: _____

Are your menstrual cycles spaced evenly? Yes No

Average number of days of flow: **Flow is:** Light Normal Heavy

Color is: Pale Dark Red Bright Red Brown

Are there blood clots present? Yes No

Does your period cause you pain or cramping? Yes No

When?: Before During After period

Do you experience any of the following symptoms before your period each month?

- Water retention
- Breast tenderness or swelling
- Mental depression
- Irritability
- Food cravings
- Migraines
- Other: _____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you get yeast infections? Yes No **How often?** _____

Do you chart your basal body temperature? Yes No

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe: _____

_____

Do you feel as if your hormones are "off"? Yes No

Pregnancies:

Year Vaginal or C-Section Complications or Conditions of Note:

_____

Women Seeking Fertility Help:

Number of months trying to conceive _____

Have you been given a diagnosis for your fertility? Yes No

Diagnosis _____

Are you using Assisted Reproductive Technology? Yes No

Which clinic? _____

# of IUIs # of Pregnancies

# of IVFs # of Miscarriages

Other # of Live Births Age of your child(ren)

Upcoming fertility procedures:_____

Men Only

Have you been diagnosed with prostate problems? Yes No

Have you experienced any of the following? ***(please circle)***

- Blood in semen
- Premature ejaculation
- Burning on ejaculation
- Low libido
- Vasectomy
- Pain or swelling in testicles?
- Penis discharge
- Painful orgasm/intercourse
- Impotence

Additional things you'd like to mention related to health or well-being, not previously covered:

_____

Thank you for taking the time to fill this form out thoroughly. It will help to serve you better

Signature: _____ Date: _____