

New Patient Intake – Fertility Female

Today's Date: ____ / ____ / ____

General Patient Information: *(All information provided is held strictly confidential--see permission to share medical information section)*

Last Name: _____ First Name: _____

Home Phone: _____ Cell: _____ Email: _____

Work Phone: _____ Occupation: _____

Street Address: _____

City: _____ Zip Code: _____

Birth Date: ____/____/____ Age: ____ Height: _____ Weight: _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Spouses Name: _____ Age: ____ Occupation: _____

In case of Emergency, who should we contact?: _____

Relationship: _____ Phone Number: _____

How did you hear about us? _____

Reason for your visit today: _____

How long have you had this condition? _____ Is it getting worse? Yes No

Does it affect your: Sleep _____ Work _____ Other _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under a physician's care now? NO YES For what? _____

Please give us the name & phone number of your:

Physician: _____

OB/GYN: _____

Reproductive Endocrinologist: _____

Reason you decided to try acupuncture & Oriental medicine? _____

How long did you think about it before you made your appointment? _____

Have you had acupuncture before? YES NO Chinese Herbal Medicines? YES NO

Surgeries: (include dates) _____

Allergies: _____

I hereby give my consent for treatment by Denise Noyer-Erez, L.Ac., and Associates.

I accept full financial responsibility for all medical services performed on my behalf.

Patient Signature

Parent/Guardian Signature

Family Medical History: *(Please check any and all condition(s) members of your family have had)*

Illness:	Father	Mother	Sibling(s)	Grandparents	Aunt/Uncle
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Drug Abuse	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Strokes	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

General Health Information:

Major Health Complaints and/or Symptoms:

1. _____
2. _____
3. _____

Please explain how these conditions affect or impair your daily activities:

Describe your symptoms when they are at their worst:

What makes your symptoms better?

Are there any other complaints or conditions that you would like us to know about?

Please list any non-prescription drugs or recreational drugs you currently take:

Medical Conditions/History: *(Circle any conditions you have had, or are currently experiencing)*

Aids/HIV	Cancer	Hepatitis	Osteoporosis	Stroke
Alcoholism	Diabetes	Herpes	Pacemaker	Thyroid Disorder
Allergies	Emphysema	Lyme Disease	Pneumonia	Tuberculosis
Appendicitis	Epilepsy	High Blood Pressure	Polio	Typhoid Fever
Arteriosclerosis	Goiter	Measles	Rheumatic Fever	Ulcers
Arthritis	Gout	Menopause	Scarlet Fever	Venereal Disease
Asthma	Heart Disease	Multiple Sclerosis	Seizures	

Gynecological History:

Age at your first period: _____
The first day of your last period? _____
Are your periods regular? YES NO Explain: _____
Number of days between periods: _____
Number of days of bleeding: _____
Amount of bleeding? (circle one) LIGHT - - - - MEDIUM - - - - HEAVY
What color is the blood? PURPLE BROWN BLACK BRIGHT RED PINK
Is there clotting? YES NO
Do you bleed or spot between periods? YES NO
Have you ever taken medication to bring on your period? YES NO
Do your breasts become tender pre-menstrually? YES NO
Do you have pre-menstrual low back pain? YES NO
Do you have pain with menstruation? YES NO
Degree of pain: MILD - - - MODERATE - - - SEVERE
Pain relieved by over-the-counter medications? YES NO
Does the pain start with the onset of bleeding? YES NO
Begin before the onset of bleeding? YES NO
Persist more than 48 hours? YES NO

Do you ovulate on your own? YES NO
Do you experience pain during ovulation? YES NO
On which day of your cycle do you ovulate? _____
Do you have vaginal discharge? YES NO
Associated with itching or burning? YES NO
Associated with unusual odor? YES NO
Do you get yeast infections? YES NO
Do you experience pain during intercourse? YES NO
Is the pain mostly external? Or internal? _____

Do you have a gynecologist? YES NO
Name and location of gynecologist: _____
When was your last pap smear? _____ Result? _____
Have you ever had an abnormal pap? YES NO
If yes, what follow up was necessary _____
Have you ever had a mammogram? YES NO

Have you ever had a sexually transmitted disease?
Chlamydia, HPV, Gonorrhea, Herpes, Other: _____
When? _____ Was it treated? _____

Do you experience milk or other discharge from your nipples? YES NO
Have you ever used an IUD? YES NO
Have you ever used the Oral Contraceptive Pill YES NO
If yes, for how long? _____ When did you last use it? _____
How long did it take for your menses to regulate? _____

Please indicate number of:

___ Pregnancies ___ Premature Births
___ Children ___ Ectopic Pregnancies
___ Miscarriages ___ IVF's - How many successful (date) ___ Unsuccessful (date) ___
___ Abortions ___ IUI's - How many successful (date) ___ Unsuccessful (date) ___

Previous Gynecological Surgeries:

Date of Procedure

C-Section Births _____
 Dilation & Curettage (D&C) _____
 Hysterosalpingogram (HSG) _____
 Hysteroscopy _____
 Laparoscopy _____
 Other: _____

Previous Diagnostic Assessments: *(please check all that apply)*

<input type="checkbox"/> Advanced Maternal Age	<input type="checkbox"/> Menorrhagia
<input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Ovarian Cyst
<input type="checkbox"/> Anovulation	<input type="checkbox"/> Ovarian Hyperstimulation Syndrome (OHSS)
<input type="checkbox"/> Cervical Stenosis	<input type="checkbox"/> Pelvic Adhesions
<input type="checkbox"/> Elevated FSH	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)
<input type="checkbox"/> Endometriosis (mild, moderate, severe)	<input type="checkbox"/> Phospholipid Antibodies
<input type="checkbox"/> Fallopian Tube Blockage	<input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)
<input type="checkbox"/> Habitual Miscarriage	<input type="checkbox"/> Premature Ovarian Failure
<input type="checkbox"/> Hostile Cervical Mucus	<input type="checkbox"/> Unexplained Infertility
<input type="checkbox"/> Hyperprolactinemia	<input type="checkbox"/> Uterine Fibroids or Polyps
<input type="checkbox"/> Luteal Phase Defect	<input type="checkbox"/> Other: _____

List any fertility drugs you have taken:

Medications you use currently: _____

Do you use tobacco? Yes _____ No _____ # Packs/day _____
 Do you use alcohol? Yes _____ No _____ # Drinks/wk _____

How long have you been trying to get pregnant? _____

Have you had a fertility workup? YES NO
 What were the results? _____

How is your sexual energy? Low Normal High
 Do you use vaginal lubricants? YES NO
 Do you have a stressful occupation? YES NO
 Do you exercise regularly? YES NO
 How often? _____

Do you have excessive facial hair? YES NO
 Do you have excessively oily skin? YES NO
 Have you experienced excessive loss of head hair? YES NO

Male Factor:

Semen Analysis: Date: _____ Count: _____ Morphology: _____ Motility: _____ Volume: _____

Overall Symptoms: *(Please circle any of the following symptoms that currently pertain to you)*

Body Temperature (Kidney & Organ System)

Cold hands	Hot body temperature	Profuse perspiration	Perspire easily
Cold feet	Cold body temperature	Lack of perspiration	Cold hips/buttocks
Sweaty palms	Afternoon Flushing	Night sweating	Incontinence
Sweaty feet	Hot Flashes	Strong thirst	Night time urination

Low back weakness or pain	Vaginal dryness
Fertile cervical mucus	Dizziness
Dark circles around your eyes	Ringing in your ears
Low back pain before your period	Low libido
Feet cold, especially at night	Early morning loose stools
Cold menstrual cramps	Premature gray hair
Colder than those around you	

Spleen Function

Energy level: High Normal Low

Poor appetite	Feel heavy/sluggish	Energy lower after a meal
Heaviness in the head	Feel bloated after eating	Poor circulation
Crave sweets	Varicose veins	Bruise easily
Loose stools	Tired around ovulation	Spot before your period comes
Abdominal pain	Tired around menstruation	Nose cold
Indigestion	Nausea	Gas
Often sick	Hypoglycemia	

Stomach Function

Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting

Blood Function (liver, spleen, and heart system)

Menses scanty or late	Difficulty concentrating
Dry skin	Fainting
Chapped lips	Blurry vision
Weak or brittle nails	Poor night vision
Losing head hair	Hair dry/brittle

Heart Function

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High blood pressure	Rapid heart beat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe shyness	Low blood pressure	Wake up in the early am

Lung Function

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies

If you are a smoker, how many cigarettes per day? _____

How long have you been smoking? _____

If you are a smoker, do you want to quit? YES NO

Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

Bowl Function and Elimination

Loose stools	Constipation	Difficulty moving bowels
I.B.S or colitis	Diarrhea	Blood in stools
Small, hard, dry stools	Crohn's disease	Incomplete stools
Mucus in stools	Less than 1 BM/Day	Eating disorder

Accumulated Dampness

Mental fogginess	Swollen hands	Edema in the legs
Mental sluggishness	Swollen feet	Edema in the abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion

Heaviness of the head, the limbs or of the whole body

Liver and Gallbladder Function

Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in the ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ringing in the ears	PMS
Breast tenderness	Nipple pain	Painful periods	
Wake with bitter taste in mouth		Difficulty falling asleep at night	
Alternating diarrhea and constipation		Easily overwhelmed by stressful circumstances	

Urinary Function

Normal color	Reddish color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination
Frequency: _____ times at night		Urgency	
_____ during the day			

Libido Function

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	

Prescription Medications & Over the Counter Medications & Supplements

Prescription Medications:

Please list by name any prescription medications you are taking on a regular basis. Enter as much of the requested information as you can. The first entry serves as an example.

Product Name	Dosage	Times per day	Prescribed by	Prescribed for
Diovan HCT	80/12.5 mg	1	Dr. Smith	High Blood Pressure

Over-the-Counter Medications and Supplements:

Please list by name any over-the-counter medications, vitamins or other supplements you are taking on a regular basis.

Brand Name	Product Name	Dosage	Times per day	Prescribed by	What it is for
Metagenics	Ultra Meal 360 Plus	52 g	2	Dr. Lee	Diabetes