Acupuncture & Skin Rejuvenation Center

PATIENT INFORMATION

Name: ____ **Date:** _______/_______/______

Sex: **Male**__________ **Female**__________

Date of Birth: _______/_______/_______ **Age:** ________
(month) (day) (year)

Marital Status: Single_____ **Married**_____ **Divorced**_____ **Widowed**_____ **# of Children**_____

Social Security Number: ____________________________________ **(optional)**

Driver's License or
Photo ID REQUIRED: _______________ ____
(State) (ID Number)

Home Address: ____

______________________________ **Home Number:** _______________________

E-Mail Address: ______________________________ **Cell Phone Number:** _____________________

Occupation: __________________________________ **Work Number:** _________________________

WHO WOULD WE CALL IN CASE OF EMERGENCY?
NAME:____
EMERGENCY TELEPHONE NUMBER: ________________________________

Do you have health insurance? Yes _____**No**_____

If yes, does your insurer cover acupuncture? Yes_____**No**_____

Name & Policy Number of Insurer (REQUIRED):

______________________________ _________________
(Insurance Company) **(Policy Number)**

Whom may we thank for referring you to our office? _______________________________________

Please list any known allergies

____

____

FERTILITY HISTORY-WOMAN

CONFIDENTIAL

NAME LAST, FIRST, MIDDLE

DATE

Age at which menses began

Are your periods painful? Yes No

How many days does the pain last?

How many days do you normally bleed?

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red/Red/Dark red/Purple/Brown/Black

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

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

Date of last menstrual period

How many pregnancies have you had?

How many children do you have? age(s)

How many abortions have you had?

How many miscarriages have you had?

How many times has a D&C been performed?

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydia infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia?

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How?

Date of last Pap smear:

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you taken any medications for gynecological conditions other than contraceptives? Yes No

Medication	Reason	How long

Have your cycles changed since they began? Yes No

How?

Do you ovulate on your own? Yes No

On what day of your cycle?

Do your breasts get tender at/during ovulation? Yes No

Do you get premenstrual low back pain? Yes No

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

Have you had fertility treatments? Yes No

If yes, when and where?

By whom?

What types?

FERTILITY HISTORY-WOMAN

CONFIDENTIAL

NAME LAST, FIRST, MIDDLE

DATE

Have you taken medication to help you ovulate? ______ Yes No
When? ______
How long? ______

Have your fallopian tubes been evaluated medically? ___ Yes No
What were the results?

Have you had any tubal operations? ______ Yes No

Have you had any hormone laboratory tests performed? Yes No
What were the results?

Do you have a single partner with whom you have been trying to conceive? ______ Yes No

How long have you been married or living together? ______

Has he had a fertility workup? ______ Yes No
What were the results?

Is your partner supportive of your wish to conceive? ___ Yes No

How is your sexual energy? Low Normal High

Do you douche regularly? ______ Yes No
With what? ______

Do you use vaginal lubricants? ______ Yes No

Are you more than 20% *over* your ideal body weight? Yes No

Are you more than 20% *below* your ideal body weight? Yes No

Do you have a stressful occupation? ______ Yes No

Do you exercise regularly? ______ Yes No

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

Have you noticed discharge from your nipples? ______ Yes No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ______ Yes No

Have you been exposed to any known environmental toxins or hormones? ______ Yes No

Are you presently taking steroids? ______ Yes No

Have you taken oral contraceptives? ______ Yes No
When? ______
How long? ______

Have you ever had an IUD? ______ Yes No
When? ______
How long? ______

Have you ever taken DepoProvera? ______ Yes No
When? ______
How long? ______

How long have you been trying to conceive? ______

Have you had a diagnosis relating to infertility? ______ Yes No
What was it?

COMMENTS/NOTES: ______