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Women's Health Information

Note: This information is confidential and will not be released without your consent.

Today's Date _____

Name _____ Date of Birth _____

Address _____

City/State/Zip _____

Phone: Home _____ Work _____ Cell _____

Email Address _____

Spouse or Partner's Name _____

EMERGENCY CONTACT _____

Phone _____ Relationship to You _____

Referred by (if applicable) _____

TODAY'S VISIT

Reason for today's visit _____

_____

Outcome you hope to achieve through acupuncture _____

_____

Have you had acupuncture before? _____ Reason? _____

Are you seeing any other alternative or complement practitioners at this time? _____

If so, when? _____

Have you seen a _____ physician _____ physical therapist _____ chiropractor for this problem?

Other therapies you have tried for this problem _____

MEDICAL HISTORY

Personal Physician _____ Date of last visit _____

List all medications and supplements you are taking. **Include vitamins and herbs.**

_____

_____

_____

List all surgeries you have had.

_____ Year_____

_____ Year_____

_____ Year_____

Other hospitalizations or serious injuries _____

Do you have a pacemaker or any other metal in your body?_____

Do you have any artificial joints? _____ Where? _____

ABOUT YOU

Occupation _____

Hobbies _____

Name/ages of children _____

Name/type of pets _____

WORDS THAT BEST DESCRIBE YOU (check all that apply)

ENERGY AND EMOTION:

___ Normal	___ Low energy	___ High energy
___ Hyperactive at times	___ Often depressed	___ Sometimes depressed
___ Worry a lot	___ Have panic attacks	___ Sleep well
___ Wake up at night	___ Difficulty falling asleep	___ Vivid dreams

THIRST:

___ Normal	___ Often thirsty	___ Thirsty, but don't drink

BODY WEIGHT:

___ Normal Would like to: _____ lose _____ gain weight

TEMPERATURE:

___ Feel cold easily ___ Feel hot or hot flashes ___ Have cold hands and feet

___ Night sweats ___ Sweat easily ___ Do not sweat when hot

APPETITE:

___ Normal ___ Abnormal ___ Often hungry

___ Poor appetite ___ Hungry, but no desire to eat

___ Gas after meals ___ Frequent nausea ___ Bloating after meals

___ Stomach pain after meals

ELIMINATION:

How many bowel movements per day: ____ 0-1 ____ 2-3 ____ 4 or more

___ Chronic or frequent constipation ___ Chronic or frequent diarrhea

___ Blood or mucus in stools ___ Alternating diarrhea and constipation

___ Blood in urine ___ Painful urination

___ Other concerns:_____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (check all that apply)

___ High blood pressure ___ Heart attack ___ Other heart problem

___ Stroke ___ Asthma ___ High cholesterol

___ Epilepsy ___ Diabetes ___ Colitis or Crohn's Disease

___ Irritable bowel ___ Diverticulosis ___ Kidney disease

___ Migraine headaches ___ Alcoholism ___ Drug addiction

___ Anemia ___ Stomach ulcers ___ Cancer

___ Obesity ___ Allergies ___ Arthritis

___ Bleeding tendencies ___ History of fainting ___ Vertigo

___ Eating disorder ___ Severe depression ___ Panic attacks

___ Severe anxiety ___ Mild Depression ___ Obsessive Compulsive Disorder

___ Bipolar Disorder ___ Hyperthyroid ___ Hypothyroid

___ Osteoporosis ___ Acid Reflux ___ Restless Leg Syndrome

List any other conditions that you have that were not listed here_____

_____

Which of the above conditions "runs" in your family?_____

_____

On average, how many beverages of beer, wine or liquor do you drink a week? _____

On average, how many cigarettes, cigars or pipes do you smoke per week? _____

Do you chew tobacco?_____ Do you smoke marijuana? _____

On average, how many hours a night do you sleep? _____

Describe your diet (use the back of this sheet if necessary) _____

_____

_____

_____

_____

_____

_____

_____

Do you exercise regularly?_____ If so, please describe what exercises and how often.

_____

_____

_____

What do you do for stress relief? _____

_____

_____

Do you practice any form of meditation? _____

_____

_____

REPRODUCTIVE ORGAN HEALTH

Have you experienced or been diagnosed with: (check all that apply)

___ Endometriosis ___ Uterine Fibroids ___ Pelvic Adhesions

___ Chlamydia ___ HIV ___ Pelvic Inflammatory Disease

___ High FSH ___ Ovarian Cysts ___ Polycystic Ovarian Disease

___ Recurring Yeast Infections

Have you ever taken birth control pills for contraception? _____ How long ? _____

Usual number of days between periods? _____

MENSTRUAL HISTORY:

Menstrual flow is usually: ___ light ___ moderate ___ heavy

___ Dark blood ___ Lots of clots in menstrual flow

___ Pain and cramping during cycle ___ Pain before onset

___ Problems with “PMS” ___ Emotional changes with cycle

Emotions associated with my cycle are: (check all that apply)

___ Depression ___ Anger ___ Irritability ___ Other

Date of last period _____ Date of last Pap Smear _____

Do you ovulate regularly? _____

Do you use an ovulation predictor kit? _____ If yes, what product? _____

Have you ever charted your basal body temperature? _____

Do you have clear, stringy mucus at the time of ovulation? _____

Do you have vaginal discharge at other times of the month? _____

Is there anything else I have not asked that you think is important for me to know?

_____

FERTILITY

How long have you been trying to conceive?_____

Dates of any miscarriages _____

Could you be pregnant now? _____

Doctors you’ve consulted for fertility (name)? _____

Doctor you’re seeing now for fertility (name)? _____

Results of a Fallopian Tubes evaluation?_____

Date/Results of a cervical biopsies _____

Infertility diagnosis (if any) _____

DATES OF USAGE OF: (if any)

Clomid/other ovulation medications _____

IUI’s _____

IVF’s _____

Have you ever taken Chinese herbs for fertility? _____

What “home” or “folk remedies” have you used to enhance fertility? _____

_____

What other fertility treatments have you tried? _____

_____

PARTNER’S FERTILITY

Has your partner had a sperm analysis? _____ Date of Sperm Analysis _____

Results: Count _____ Motility _____ Morphology _____

Does your partner have a varicocele (varicose vein in the testicles)? _____

If yes, was it repaired? _____

KYn

Do you have lower back weakness, soreness, or pain or knee problems?	YES	NO
Do you have ringing in your ears?	YES	NO
Do you get dizzy frequently?	YES	NO
Is your hair prematurely gray?	YES	NO
Do you have vaginal dryness?	YES	NO
Do you get clear, egg white vaginal mucus at ovulation time?	YES	NO
Do you have dark circles around or under your eyes?	YES	NO
Do you have night sweats?	YES	NO
Are you prone to hot flashes?	YES	NO
Would you describe yourself as being afraid a lot?	YES	NO

KYg

Do you have lower back pain before your period?	YES	NO
Is your low back sore or weak?	YES	NO
Are your feet cold, especially at night?	YES	NO
Are you typically colder than those around you?	YES	NO
Is your libido low?	YES	NO
Are you often fearful?	YES	NO
Do you wake up during the night/early morning because you have to urinate?	YES	NO
Do you urinate frequently, and is the urine diluted or profuse?	YES	NO
Do you have early morning loose or urgent stools?	YES	NO
Does your menstrual blood tend to be dull in color?	YES	NO
Do you feel cramps during your period that tend to respond to a heating pad?	YES	NO

SP

Are you often fatigued?	YES | NO
Do you have poor appetite?	YES | NO
Is your energy low after a meal?	YES | NO
Do you feel boated after a meal?	YES | NO
Do you crave sweets?	YES | NO
Do you have loose stools, abdominal pain, or digestive problems?	YES | NO
Are your hands and feet cold?	YES | NO
Do you wear socks to bed?	YES | NO
Are you prone to feeling heavy or sluggish?	YES | NO
Are you prone to feeling heaviness or grogginess in your head?	YES | NO
Do you bruise easily?	YES | NO
Do you think you have poor circulation?	YES | NO
Do you have varicose veins?	YES | NO
Are you lacking strength in your arms and legs?	YES | NO
Do you exercise infrequently?	YES | NO
Do you worry often?	YES | NO
Have you been diagnosed with low blood pressure?	YES | NO
Do you sweat a lot with out exerting yourself?	YES | NO
Are you dizzy/lightheaded/have visual changes when standing up quickly?	YES | NO
Do you ever spot a few days before your period starts?	YES | NO
Have you ever been diagnosed with uterine prolapse?	YES | NO
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	YES | NO
Are you often sick?	YES | NO
Do you have allergies?	YES | NO
Have you been diagnosed with hypothyroid?	YES | NO
Have you been diagnosed with anemia?	YES | NO
Do you have hemorrhoids?	YES | NO
Do you have polyps?	YES | NO

BDf

Are your menses scanty and/or often late?	YES	NO
Do you have dry, flaky skin?	YES	NO
Are you prone to getting chapped lips?	YES	NO
Are your fingernails or toenails brittle?	YES	NO
Is your hair thinning?	YES	NO
Is your hair brittle or dry?	YES	NO
Do you have diminished nighttime vision?	YES	NO
Do you get dizzy or lightheaded around your period?	YES	NO

BSt

Is your menstrual flow ever brown or black in color?	YES	NO
Do you feel mid-cycle pain around your ovaries?	YES	NO
Do you have painful, unmovable breast lumps?	YES	NO
Do you experience periodic numbness of your hands or feet, especially at night?	YES	NO
Do you have varicose or spider veins?	YES	NO
Do you have red hemangiomas (cherry-red spots) on your skin?	YES	NO
Do you have chronic hemorrhoids?	YES	NO
Does your menstrual blood contain clots?	YES	NO
Have you been diagnosed with endometriosis?	YES	NO
Have you been diagnosed with uterine fibroids?	YES	NO
Is your lower abdomen tender to palpation?	YES	NO
Do you have piercing or stabbing menstrual cramps?	YES	NO
Have you been diagnosed with any blood clotting disorder?	YES	NO
Have you ever had a blood clot?	YES	NO

LvQiXt

Are you prone to emotional depression?	YES	NO
Are you prone to anger and/or rage?	YES	NO
Do you become irritable before your period?	YES	NO
Do you become bloated before your period?	YES	NO
Do you feel bloated around ovulation time?	YES	NO
Does it feel as if your ovulation is lasts longer than it should?	YES	NO
Are your breasts sensitive or sore around ovulation?	YES	NO
Do you experience nipple pain or discharge from your nipples?	YES	NO
Do you have a lot of premenstrual breast pain or distention?	YES	NO
Have you been diagnosed with elevated prolactin levels?	YES	NO
Do you often feel irritable around ovulation?	YES	NO
Do you have heartburn?	YES	NO
Do you wake up with a bitter taste in your mouth?	YES	NO
Are your menses painful?	YES	NO
Do you feel menstrual cramps in your external genital area?	YES	NO
Is your menstrual blood thick and dark or purplish in color?	YES	NO
Do you experience “floaters” in your eyes?	YES	NO
Do you have difficulty falling asleep at night?	YES	NO

HtDef

Do you wake up early in the morning and have difficulty falling back asleep?	YES	NO
Do you have heart palpations, especially when anxious?	YES	NO
Do you have nightmares?	YES	NO
Do you seem low in spirit or lacking in vitality?	YES	NO
Are you prone to agitation or extreme restlessness?	YES	NO
Do you fidget?	YES	NO
Do you sweat excessively, especially on your chest?	YES	NO

XHT

Are your mouth and throat usually dry?	YES	NO
Are you thirsty for cold drinks most of the time?	YES	NO
Do you often feel warmer than those around you?	YES	NO
Do you ever wake up sweating?	YES	NO
Do you have hot flashes?	YES	NO
Do you break out with red acne, especially before your period?	YES	NO
Do you have vaginal irritations or rashes?	YES	NO

D

Do you feel tired and sluggish after a meal?	YES	NO
Do you have fibrocystic breasts?	YES	NO
Do you have acne?	YES	NO
Does your menstrual blood contain stringy tissue or mucus?	YES	NO
Are you prone to yeast infections?	YES	NO
Do you have frequent vaginal itching?	YES	NO
Do your joints ache, especially with movement?	YES	NO
Are you overweight?	YES	NO

DH

Do you have foul-smelling, yellow or greenish vaginal discharge?	YES	NO

CW

Does your lower abdomen feel cooler to the touch than the rest of your torso?	YES	NO