Vitality Holistic Medicine

PATIENT HISTORY

Name _____ DOB _____ Sex (circle one): F / M / T

Home address _____ City _____

State _____ Zip _____ Cell phone _____

Alternate contact number _____ Email _____

Primary care physician and contact number _____

Who referred you to our office? _____

Emergency contact name and number _____

Occupation _____ Have you had acupuncture before? _____

Ob/gyn or reproductive endocrinologist and contact number _____

Please check the following applicable statements and provide further info if asked:

_____ I have allergies to _____

_____ I have a pacemaker _____ I take Coumadin/warfarin _____ I take lithium

_____ I drink caffeine Type _____ # of cups daily _____

_____ I use tobacco Type _____ # of cigarettes per day_____ # of yrs _____

_____ I drink alcohol Type _____ # of drinks per week _____

_____ I drink soda (regular or diet) Type _____ # per week _____

_____ I use recreational drugs Type _____ # of times per week _____

Please list any medications and supplements you're currently taking:

Medicine	Dosage	Reason	How long	Date of last checkup

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Family history: Please check the applicable illnesses below for you and any immediate blood relatives (parent, sibling, grandparent) and give an approximate date of onset:

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer	____	_____	_____	Hepatitis	____	_____	_____
Diabetes	____	_____	_____	TB	____	_____	_____
Heart disease	____	_____	_____	Depression	____	_____	_____
Hypertension	____	_____	_____	Seizures	____	_____	_____
MRSA	____	_____	_____	HIV	____	_____	_____
Rheumatic fever	____	_____	_____				
Other emotional disorders (bipolar, schizophrenia)					____	_____	_____

What are you chief complaints (from most to least problematic)? _____

_____

_____

What other forms of treatment have you sought? _____

_____

What kind of exercise do you do and how often? _____

_____

What are your goals in seeking acupuncture (fertility help, pain relief, stress management, etc.)?

1. _____

2. _____

3. _____

List any food allergies/sensitivities (provide approx date of onset) _____

_____

_____

List any injuries, accidents, surgeries or hospitalizations with approx. date _____

_____

_____

How do you feel about the following areas of your life (check the appropriate blank)?

	Great	Good	Fair	Poor	Bad	Comments
Significant other	_____	_____	_____	_____	_____	_____
Family	_____	_____	_____	_____	_____	_____
Diet	_____	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____	_____
Self	_____	_____	_____	_____	_____	_____
Work	_____	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____	_____

FOR WOMEN:

Are you pregnant (y/n/maybe) _____ Date of last period _____ Age at first period _____

Number of pregnancies _____ Number of live births _____ Number of abortions _____

Number of miscarriages (please provide dates and gestational age) _____

_____

Did you conceive naturally? _____ History of pre-term pregnancies or complications:

_____

Date of last gynecologic exam _____ Date of last PAP test _____

Date of last mammogram _____ Date of last bone density scan _____

Date of last colonoscopy_____

Date of last blood panel (glucose, cholesterol, blood count, etc.) _____

Note any out of range/borderline test results _____

_____

Are your periods regular? _____ Avg. length of entire cycle (e.g., 28 days) _____

Days of flow _____ Color of blood flow _____ Are there clots? _____

Heavy, light or average flow _____ Is your period painful? _____

Is the pain before, during or after_____

How long does pain last? _____ Location of pain (abdomen, back, breasts, thighs or elsewhere) _____

Please circle any other symptoms/conditions related to your menses: discharge, nausea/vomiting, swollen breasts, poor appetite, ravenous appetite, increased libido, decreased libido, vaginal dryness, constipation, loose stools, mood swings, hot flashes, headache, night sweats, insomnia, depression, PCOS, endometriosis, other _____

_____

Describe any pain or symptoms mid-cycle (around ovulation) _____

Approximately what day of cycle does it start: _____

How long do symptoms last? _____ Fertile mucus and duration: _____

Are you using a BBT chart (please bring to appointment or send prior): _____

History of yeast infections: _____

History of UTI: _____

History of sexually transmitted infections: _____

FERTILITY HISTORY

Please provide the name and contact number of your ob/gyn or reproductive endocrinologist:

_____

Describe any ART you have tried (or are planning) and dates: _____

_____

_____

Have you (or your partner) been diagnosed with the following (include related diagnostic tests and dates):

Endometriosis _____

Blocked tubes _____

PCOS _____

Amenorrhea or Oligomenorrhea _____

Premature ovarian failure _____

PID _____

Fibroids _____

Thyroid disorders _____

Anatomical disorders _____

Male factor _____

"Unexplained" _____

Ovarian hyperstimulation syndrome _____

Other _____

Please note lab results (or bring recent lab work if you have it):

Test	Values	Date
Antral follicle count (AFC)		
FSH		
LH		
AMH		
Estradiol (estrogen)		
Inhibin B		
Progesterone		
Prolactin		
Testosterone/DHEA		
17-hydroxy progesterone		
Insulin		
Other:		
Other:		

Are you using an ovulation kit? _____ Results? _____

_____

Is your partner willing to come for acupuncture or take herbs? _____

Questions / concerns about acupuncture and herbs? _____

_____

_____

Questions / concerns about ART? _____

_____

_____