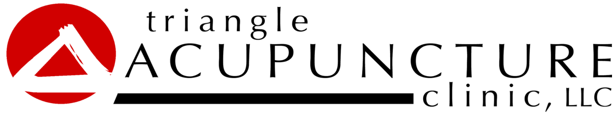

Welcome to Triangle Acupuncture Clinic. To help us provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have questions please ask us. Thank you for your time.

CONTACT INFORMATION

Name: Today's Date:

Street Address:

City: State: Zip:

Primary Phone: ( ) circle: home work cell

Secondary Phone: ( ) circle: home work cell

Circle the Best Number to Reach You: primary secondary

Email Address:

In Case of Emergency, Contact: Phone: ( ) circle: h w c

Birth Date: How did you hear about us?

Marital/Relationship Status: Occupation:

Age: Height: Weight: Sex:

Primary Physician's Name: Date of last visit:

OB/GYN's Name: Date of last visit:

Reproductive Endocrinologist's Name: Date of last visit:

Other Health Care Providers You See Regularly and For What Conditions:

FERTILITY HISTORY

Age period began: How many days do you normally bleed?

How heavy is the bleeding? Light Medium Heavy

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

What is the consistency of the blood? Watery Thick Clots Dry Phlegmy

Do you suffer from painful periods? When and how many days do you have pain?

Check yes or no	**Yes**	**No**
Premenstrual Moodiness		
Premenstrual Low Back Pain		
Premenstural Acne or Breakouts		
Premenstural Breast Tenderness		
Loose Bowels Premenstrually or During Period		
Premenstrual Water Retention or Bloating		
Bleed or Spot Between Periods		
Do you douche?		
Do you use vaginal lubricants during sex?		

Does your menstrual cycle follow a regular pattern?

How many days from the start of one period to the start of another?

Do you ovulate on your own? On what day of your cycle?

Have your cycles changed since they began or at anypoint in time recently? How?

Date of last menstrual period: Number of pregnancies:

Number of children and ages: Number of abortions:

Number of miscarriages: Number of times a D & C has been performed:

Please circle and indicate the date if you have had any of the following:

abnormal PAP smear

venereal disease

chlamydia

yeast infection

endometriosis

pelvic adhesions

hemorrhage

chronic vaginal discharge

pelvic inflammatory disease

uterine fibroids or polyps

genital sores

pelvic abnormalities

cervical biopsy/operation

other:

Please list any medications you have taken for any other gynecological conditions:

Have you ever taken oral contraceptives? When and for how long?

Have you ever had an IUD or taken DepoProvera? When and for how long?

How long have you been trying to conceive?

Cause of Infertility (doctor's diagnosis):

Are your fallopian tubes open? Have you had abdominal surgery?

What is your day 3 FSH? AMH? Prolactin level?

Have your estrogen or progesterone levels been found to be low?

Have you had your thyroid tested? Antibodies?

Describe in chronological order all other fertility treatments (injectables, IUI, IVF, FET):

Date (month/year):

Date:

Date:

Date:

Date:

Date:

Date:

Date:

Is your partner supportive of your wish to conceive? ______

Male partners: Has he had a fertility workup? Results? ______

How is your sexual energy?   Low   Normal   High

How is your relationship with your partner now?   Not Good   Stressed   Good   Awesome

Do you have a support system of friends and family? ______

Describe your stress level and any predominant emotions you are experiencing: ______

______

______

What do you currently do to promote relaxation and combat stress? ______

______

Any other thoughts or information related to your physical or emotional health that you would like to share? ______

______

______

______

CURRENT HEALTH

How many glasses of water do you drink per day? ______

What other beverages do you consume daily? ______

Briefly describe your diet and any special diets: (use the back if needed) ______

______

______

______

______

______

Do you smoke/chew tobacco? ______ How much and how often? ______

Do you consume caffeine? ______ How much and how often? ______

Do you consume alcohol? ______ How much and how often? ______

Do you use recreational drugs? ______ How much and how often? ______

Please list all vitamins and supplements you are taking: ______

______

______

______

______

please continue to next page

Please list all prescription and over-the-counter medications you are taking, dosages for each and why you are taking each: (use the back of form if more room is needed):

List any drug allergies:

PAST AND FAMILY MEDICAL HISTORY

Please list any major illnesses and operations, and the date of onset of each:

Date of last PAP: Date of last mammogram:

Please check all that apply:

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Anemia							
Cancer							
Diabetes							
High Blood Pressure							
Stroke							
Heart Disease							
Depression							
Mental Illness							
Hepatitis							
HIV/AIDS							
Autoimmune Disease							
Infectious Disease							
MRSA/Staff Infection							
Other							
Age at Death							

Please continue to the following forms: HIPAA, Office Policy, and Arbitration/Informed Consent (front and back)