

# Acupuncture & Oriental Medicine

## 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: \_\_\_\_\_

### Please list all medications and supplements you are currently taking:

Medications/Supplements/Dosage	Reason/Objective	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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)*

<b>Illness:</b>	<b>Father</b>	<b>Mother</b>	<b>Sibling(s)</b>	<b>Grandparents</b>	<b>Aunt/Uncle</b>
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, 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*

**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	Ring 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	