Access Acupuncture
New Patient Health History & Fertility

Name: _____Date: _____/_____/_____
(first) (middle) (last)

Address_____ City/State/Zip_____

Phone_____Email_____

Emergency Contact Name & Phone_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M or F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Chief complaints Date of onset Severity of symptoms (1-10)

_____

_____

_____

_____

On a scale of 1-10 (10 being extremely motivated) how motivated are you to take control of the above complaints? _____

When and where did you last receive health care? _____

For what reason? _____

Primary Physician's Name and Phone #_____

Have you had Acupuncture before? Y N Herbal Medicine? Y N

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): _____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

Height: _____ **Weight:** _____ Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When?_____

Successful fertility treatments are possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. If there are areas of confusion, please note with a question mark. This information is kept strictly confidential. Thank you.

Age at which menses began_____ Date of last Menstrual Period_____
Are your menstrual cycles regular? Y N How many days? _____
Are your periods painful? Y N How many days does the pain last? _____
How many days do you normally bleed? _____ Is there clotting? Y N
What color is the blood? Light Red Red Dark Red Purple Brown Black

Do you have PMS? Y N When does it begin? _____
Does your face break out before or during your period? Y N
Do your breasts become tender premenstrually? Y N
Do you get premenstrual low back pain? Y N
Do your bowel movements become loose at the beginning of your period? Y N
Do you bleed or spot between periods? Y N

	Number	Year(s)
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many Ceasarean sections?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times have you had a D & C?	_____	_____

Date of last PAP Smear?_____Have you ever had an abnormal PAP smear? Y N
Have you ever had a STD? Y N If yes, what was it and when? _____
Do you get yeast infections regularly? Y N Urinary Tract Infections? Y N
Do you have chronic vaginal discharge? Y N Do you have genital sores? Y N
Have you ever had Pelvic Inflammatory Disease? Y N
Where you treated for it? Y N How_____

Have you ever been diagnosed with uterine fibroids or polyps? Y N
Have you ever been diagnosed with endometriosis? Y N
Have you ever been diagnosed with pelvic adhesions? Y N
Have you ever been diagnosed with any pelvic abnormalities? Y N

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long

Have your cycles changed since they began? Y N
How? _____
Do you ovulate on your own? Y N On what day of your cycle? _____
Have you taken medication to help you ovulate? Y N
When _____ How long? _____

How long have you been trying to conceive? _____
Have you had a diagnosis relating to infertility? Y N What was it? _____
Have you had fertility treatments? Y N
If yes, when and where? _____
By whom? _____
What types? _____

Have your fallopian tubes been evaluated medically? Y N
What were the results? _____
Have you had any tubal operations? Y N
Have you had any hormone laboratory tests performed? Y N
What were the results? _____

Do you have a single partner with whom you've been trying to conceive? Y N
How long have you been married or living together? _____
Has he had a fertility work up? Y N
What were the results? _____
Is your partner supportive of your wish to conceive? Y N

Have you taken oral contraceptives? Y N
When _____ How long? _____
Have you ever had an IUD? Y N
When _____ How long? _____
Have you ever taken DepoProvera? Y N
When _____ How long? _____

How is your sexual energy? Low Normal High

Do you douche regularly? Y N With what? _____
Do you use vaginal lubricants? Y N

Are you more than 20% over your ideal body weight? Y N
Are you more then 20% below your ideal body weight? Y N

Do you have a stressful occupation? Y N What?_____
Do you exercise regularly? Y N What form?_____

Do you have excessive facial hair? Y N
Do you have excessively oily skin? Y N
Have you experienced excessive loss of head hair? Y N
Have you noticed discharge from your nipples? Y N

Was your mother exposed to diethylstilbestrol (DES) when she was
pregnant with you? Y N
Have you been exposed to any know environmental toxins or hormones? Y N
Are you presently taking steroids? Y N

Thank you for taking the time to fill out this health questionnaire. We look forward to working with you on your fertility journey.

I certify that the above information is complete and accurate to the best of my knowledge. I will notify my practitioner with any changes that may occur during the course of my treatment.

I understand that my condition may need to be co-managed so I authorize my treating acupuncturist and this office to contact my other medical providers.

_____ _____
Name Date