Health History Questionnaire

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask us. If there is anything you wish to bring to our attention which is not included on this form, use the comments area at the end or attach a separate sheet. Thank you!

Name: _____ Phone Home: _____ Cell: _____
Email: _____
Street: _____ City: _____ State: _____ Zip: _____
Age: _____ Height: _____ Weight: _____ Gender: _____
Occupation: _____ Marital Status: _____
Physician: _____ Referred by: _____
Emergency Contact: _____ Phone: _____
Main Problem: _____ Onset: _____
Have you tried acupuncture or Chinese herbs before? _____ Yes _____ No
Other Concurrent Therapies: _____

Gynecological

___Painful Menses ___Heavy/Light Menstrual Flow ___Menstrual Clots ___Miscarriages ___Abortions
Age at Menopause _____
Number of Pregnancies _____

Fertility Treatments

___ IVF - Number of Treatments _____
1st IVF: number of eggs retrieved ____ number fertilized____ Final outcome: _____
2nd IVF: number of eggs retrieved ____ number fertilized____ Final outcome: _____
3rd IVF: number of eggs retrieved ____ number fertilized____ Final outcome: _____
___IUI – Number of Treatments ___
FSH Level (if known) _____
Genetic screening PGD/PGS: ___Yes ___No
Do you currently participate in Hormone Therapy? ___Yes ___No
___Endometriosis ___PCOS ___Documented Ovarian Failure ___Scar Tissue
___Blocked Fallopian Tubes
___Other:_____

Past Medical History

Significant Illnesses: ___Cancer ___Diabetes ___HIV ___Hepatitis ___Allergies ___Seizures
___High Blood Pressure ___Heart Disease ___Rheumatic Fever ___Thyroid Disease __Venereal
___Surgeries (please describe) _____

___Trauma (accidents, falls, etc.) _____
___Medicine Taken (include Vitamins, Herbs, Over the Counter Drugs, etc.): _____
_____
___Habits: ___Cigarettes ___Coffee ___Tea ___Cola ___Alcohol ___Drugs ___Sugar

General

___ Poor Appetite ___Insomnia ___Cold Hands/Feet ___Fever ___Thirst ___Fatigue ___Chills
___Night/Day Sweats ___Bruising/Bleeding Easily ___Head Aches ___Skin/Hair Problems
___Other Pains (specify location): _____
___Eyes/Ears/Nose ___Dizziness ___Asthma ___Cough ___Nausea ___Vomiting ___Diarrhea
___Constipation ___Hemorrhoids ___Indigestion ___ Rectal Pain ___Kidney/Gall Stones
___ Blood in Stool/Urine ___Pain on Urination ___Frequent Urination ___Impotence
Do you wake up at night to urinate? ___Yes ___No How often? _____
Urine color: _____ Other Genital/Urinal problems: _____
___Poor Memory ___Loss of Balance ___Depression ___Anxiety ___Anger
___Psychological/Emotional Problems ___Ever Considered or Attempted Suicide?

Family Medical History

___Diabetes ___Cancer ___Blood Pressure ___Heart Disease ___Stroke ___Seizures
___Asthma ___Allergies ___Alcoholism
___Other: _____

Additional comments: