Point to Health

ACUPUNCTURE llc
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Patient Health History-Women's Health-Fertility

Name_____
Significant Other Name_____
Date_____
Primary GYN/OBG/MD/ND_____
How long have you been attempting conception?_____
_____
Reasons you are coming to Point to Health Acupuncture LLC._____
_____
DOB_____Age_____
Significant Other DOB_____Age_____
Number of years together_____
Marital Status_____

Pregnancy history:
Times pregnant_____
Births_____
Miscarriages_____
Abortions_____
Adopted Children_____

Dates of pregnancies_____
Have you worked with a doctor for fertility purposes?_____
Contraception History_____
_____
Operations/Hospitalizations_____
_____
Medications/Supplements/Herbs you are taking_____
_____
Allergies(Medications/Foods/Seasonal/Other_____
_____
Menstrual History:

Height _____Weight_____Blood Type_____
Age at first period_____
Date of last two menstrual periods____/____/____ and ___/___/___
Are your periods regular?_____Do you bleed between periods?_____
How many days from onset to onset?_____
What is the usual duration of your periods?_____days
Do you experience pre menstrual symptoms?_____almost always____rarely____never
Vigorous Exercise: type_____hrs/wk_____
If you have a known hormonal disorder, please specify type and treatment_____
_____
_____
_____

Last Pap Smear___/___/___ Last Mammogram___/___/___

Pelvic pain/cramps ___none____during menses____before menses____after menses ____at midcycle____during intercourse____with bowel movements____with urination ____cause you to miss work____cause you to miss usual activities

Pelvic pain/cramps are ____mild____moderate____severe____worsening____improving ____no change____in midline____on right side____on left side

Frequency of intercourse_____

Please check all that apply:

Do you have or have you had?____Hot flashes____Breast discharge____Visual disturbances____Poor sense of smell____Chronic headache____Head trauma____Increased body or facial hair____Increased acne____Weight increase ____Weight loss____Special dietary habits____Vomiting____Seizures____Diabetes ____Thyroid disorder____Autoimmune disease____Extraordinary stress____Psychiatric treatment

Please explain a yes answer_____
_____

Gynecologic Infection
Do you or have you had:
___Pelvic infection____Appendicitis____Gonorrhea____Ovarian Cysts____Chlamydia ____Colitis or enteritis____Syphillis____Toxoplasmosis____Endometriosis____Uterine fibroids or myomas____Mycoplasma____Cytomegalovirus(CMV)____Pelvic adhesions ____Abnormal uterus shape____Ureaplasma____Tuberculosis____Cervicitis ____Recurrent vaginitis____Genital warts/condyloma____Trichomonas____Genital Herpes____Abnormal pap smears____Cryo(freezing) or surgery of the cervix

Other History:
Your occupation_____Spouse's occupation_____
_____

Do you use any of the following, and if so how much?
Alcohol_____
Cigarettes_____
Marijuana_____
Other drugs_____
Caffeine drinks per day_____
Computer use per day_____
Electric blanket use_____
Any toxic exposure_____
IV drugs_____
Hot tub/Sauna_____
Radiation exposure_____

Medical Illnesses:
Do you have or have you had?
____Cancer____Diabetes____Hypertension____High Cholesterol____Heart Disease
____Rheumatic Fever____Scarlet Fever____Mitral Valve Prolapse____Heart Murmur
____Asthma____Pneumonia____Bronchitis____Tuberculosis____Hepatitis/Liver
disorder____Gall bladder problems____Ulcers____Colitis/Enteritis____Kidney disorder
____Rubella____Anesthetic complication____Mumps____Chicken
Pox____Mononucleosis____Serious injury/accident____Blood
transfusion____Psychiatric disorder____Seizures____Stroke____Blood Clots
____Anemia____Bleeding disorder____Thyroid disorder____Recent Immunization

Please explain a "Yes" answer to any of the above_____
_____
_____
_____

Family History

	Living?	Age or age at death	Health Problems
Mother			
Father			
Sisters			
Brothers			

Which of your blood relatives have?
Cancer_____
Venous Thrombosis(blood clotting)_____
Diabetes_____
Hypertension_____
High Cholesterol_____
Heart Disease_____
Stroke_____
Premature Menopause_____
Endometriosis_____
Uterine Fibroids(myomas)_____

Genetic History: Do you, your partner, or anyone in either family have?
_____Any Inherited disorders?

____Neural tube defects/spinabifida/anencephaly____Cystic fibroids____Tay Sachs disease____Chromosomal disorder____Thalassemia____Muscular dystrophy
____Sickle cell disease or trait____Genetic/inherited disorder____Down Syndrome
____Huntington chorea____Hemophilia____Baby with birth defects____Infertility
____Hormonal disorder____Mental retardation/fragile X

Please explain a "Yes" answer to any of the above:_____
_____
_____

Systemic Review:
____Headaches___number per week____medication used
____Mild____Moderate____Severe____Improving____Worsening____No change
____With visual symptoms____vith vomiting____stress related____migraines

____Wear glasses____Bladder Kidney infections____Abdominal pain____Acne
____Wear contact lenses____Urgent/frequent/painful urination____Nausea/vomiting
____Skin disorder____Sinus problems____Blood/abnormal color of urine____Vomiting blood____Rash____Hives____Ulcer____Hayfever____Unable to control urination
____Ringing in ears____Abnormal urinary tract____Food intolerance____Skin cancer
____Hearing loss____Kidney x-ray____Gallstones____Denture/bridges___Bladder cystoscopy____Jaundice/hepatitis____Counseling____Chronic constipation____Recent stress increase____Anemia____Varicose veins____Blood in bowel movement____Diarrhea____Chest pain____Easy bruising____Irregular heart beat____Prolonged bleeding____Irritable bowel movement____Irregular heart beat
____Sensation loss/numbness____Fainting spells____Bleeding from gums____Hemorrhoids____Muscle control/weakness____Leg swelling____Nosebleeds____Hernia____Heat or cold intolerance____Calf pain____Nosebleeds____Take aspirin/ibuprofen frequently____Abnormal liver

test____Damp skin____Blood clots(venous thromboembolism)____Arthritis____Back pain____Unusual hair loss____Extraordinary fatigue____Cough____Breast mass____Shortness of breath____Fibrocystic changes____Wheezing____Breast implants ____Cough up blood____Mammogram____Chest x-ray____Do monthly breast exam____TB skin test

Other:_____
_____
_____
_____

Male History:
____Medications____Reproductive surgery____STD's____Testicular trauma____Impotence____Illnesses____Mumps____Smoker____Alcohol ____Ejaculatory disorder___Allergies, yes what are your allergies_____
_____
Have you seen a urologist for infertility?_____If yes, Physician name and location_____
_____

Have you ever fathered a child/pregnancy with another woman?_____
Have you ever been diagnosed with an infertility diagnosis except for currently?_____
If yes, when?_____years ago_____

Comments_____
_____
_____

History of fertility therapy(fill out if applicable)

Have you been treated for infertility previously?_____
If yes, who was your physician?_____

What cause of infertility was diagnosed?_____
_____
_____

What drugs have you taken for infertility? Please check all that apply:
____Clomid_____Gonal F_____Follistim_____Repronex_____Pergonal _____Fertinex_____hCG Profasi_____Progesterone_____Lupron _____Microdose Lupron_____Anatagon_____Parlodel_____Antibiotics _____Baby Aspirin_____Heparin_____Steroids_____Oral Contraceptives _____Other

Which of the following have you or your partner had performed? Please check all that apply and results, if known:

_____BBT
_____Postcoital Test
_____Hormonal Assays(FSH, LH,Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone)
_____Endometrial biopsy
_____Hysterosalpingogram
_____Sonohystogram
_____Ultrasound
_____Laparoscopy, Hysteroscopy
_____Mycoplasma culture
_____Chlamydia culture
_____GC culture
_____Thyroid tests
_____Rubella(German measles)
_____Varicella(chicken pox)
_____Cytomegalovirus(CMV)
_____Antibody screen
_____Blood type
_____Chromosomes
_____Genetic screening
_____Hepatitis B
_____Hepatitis C
_____HIV
_____HTLV
_____RPR(Serology)
_____Semen Analysis
_____Antisperm antibodies
_____Varicocele repair
_____Testicular biopsy
_____Other

To any of the previous checked tests that you have had, when did you have the test and what were the results?_____
_____

Have you ever undergone Artificial Insemination(IUI) or In Vitro Fertilization(IVF)?_____
If yes, with partner or donor sperm_____
Clomid_____ Fertility shots_____Name of medications_____
#IUI's_____Dates
#IVF cycles_____Dates_____

Please check any of the following that apply:

Ki Yin Xu

Do you have lower back weakness, soreness, or pain, or knee problems?___
Do you have ringing in the ears or dizziness?___
Is your hair prematurely gray?___
Do you have vaginal dryness?___
Is your midcycle fertile cervical mucus scanty or missing?___
Do you have dark circles around or under your eyes?___
Do you have night sweats?___
Are you prone to hot flashes?___
Would you describe yourself as afraid a lot?___
Does your tongue lack coating?___
Does your tongue appear shiny or peeled?___

Ki Yang Xu

Do you have lower back pain premenstrually?___
Is your low back sore or weak?___
Are your feet cold, especially at night?___
Are you typically colder than those around you?___
Is your libido low?___
Are you often fearful?___
Do you wake up at night or early in the morning because you have to urinate?___
Do you urinate frequently, and is the urine diluted and/or profuse?___
Do you have early morning loose, urgent stools?___
Do you have profuse vaginal discharge?___
Does your menstrual blood tend to be dull in color?___
Do you feel cold cramps during your period that respond to a heating pad?___
Is your tongue pale, moist, and swollen?___

Sp Qi Xu

Are you often fatigued?___
Do you have a poor appetite?___
Is your energy lower after a meal?___
Do you feel bloated after eating?___
Do you crave sweets?___
So you have loose stools, abdominal pain, or digestive problems?___
Are your hands and feet cold?___
Is your nose cold?___
Are you prone to feeling heavy or sluggish?___
Are you prone to feeling heaviness or grogginess in the head?___
Do you bruise easily?___
Do you think you have poor circulation?___
Do you have varicose veins?___
Are you lacking strength in your arms or legs?___
Are you lacking in exercise?___

Are you prone to worry?___
Have you been diagnosed with low blood pressure?___
Do you sweat a lot without exerting yourself?___
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?___
Is your menstruation thin, watery, profuse, or pinkish in color?___
Are you more tired around ovulation or menstruation?___
Do you ever spot a few days or more before your period comes?___
Have you ever been diagnosed with uterine prolapse?___
Are your menstrual cramps accompanied by a bearing down sensation in your uterus?___
Are you often sick, or do you have allergies?___
Have you been diagnosed with hypothyroid or anemia?___
Do you have hemorrhoids or polyps?___
Does your tongue look swollen, with teeth marks on the sides?___
Do you have a pale yellowish complexion?___

Bl Xu
Are your menses scanty and/or late?___
Do you have dry, flaky skin?___
Are you prone to getting chapped lips?___
Are your fingernails or toenails brittle?___
Are you losing hair on your head(not in patches, but all over)?___
Is your hair dry or brittle?___
Do you have diminished nighttime vision?___
Do you get dizzy or light headed around your period?___
Are your lips, the inner side of your lower eyelids, or tongue pale in color?___

Bl Stasis
Is your menstrual flow ever brown or black in color?___
Do you feel midcycle pain around your ovaries?___
Do you have painful, unmovable breast lumps?___
Do you experience periodic numbness of your hands and feet(especially at night)?___
Do you have varicose or spider veins?___
Do you have red hemangiomas (cherry red spots) on your skin?___
Does your complexion appear dark and “sooty”?___
Do you have chronic hemorrhoids?___
Does your menstrual blood contain clots?___
Have you ever bee diagnosed with endometriosis or uterine fibroids?
Is your lower abdomen tender to palpation(resisting touch)?___
Can you feel any abnormal lumps in your lower abdomen?
Do you have piercing or stabbing menstrual cramps?
Does your tongue look dark?___
Do you have dark spots on your tongue?___
Are the veins beneath your tongue twisty and tortuous?___
Do you have dark spots in your eyes?___
Have you been diagnosed with any vascular abnormality or blood clotting disorder?___

Lr Qi Stag
Are you prone to emotional depression?___
Are you prone to anger and/or rage?___
Do you become irritable premenstrually?___
Do you feel bloated or irritable around ovulation?___
Does it feel as if your ovulation lasts longer than it should?___
Are your breasts sensitive/sore at ovulation?___
Do you experience nipple pain or discharge from your nipples?___
Do you have a lot of premenstrual breast distention or pain?___
Have you been diagnosed with elevated prolactin levels?___
Do you become bloated premenstrually?___
Are your pupils usually dilated and large?___
Do you have difficulty falling asleep at night?___
Do you experience heartburn or wake up with a bitter taste in your mouth?___
Are your menses painful?___
Do you feel your menstrual cramps in the external genital area?___
Is the menstrual blood thick and dark, or purplish in color?___
Is your tongue dark or purplish in color?___

Heart Xu
Do you wake up early in the morning and have trouble getting back to sleep?___
Do you have heart palpiations, especially when anxious?___
Do you have nightmares?___
Do you seem low in spirit or lacking in vitality?___
Are you prone to agitation or extreme restlessness?___
Do you fidget?___
Is the tip of your tongue red?___
Is there a crack in the center of your tongue that extends to the tip?___
Do you sweat excessively, especially on your chest?___

Shi Heat
Is your pulse rate rapid?___
Are your mouth and throat usually dry?___
Are you thirsty for cold drinks most of the time?___
Do you often feel warmer than those around you?___
Do you wake up sweating or have hot flashes?___
Do you break out with red acne(especially premenstrually)?___
Do you have a short menstrual cycle?___
Do you have vaginal irritation or rashes?___

Dampness
Do you feel tired and sluggish after a meal?___
Do you have fibrocystic breasts?___
Do you have cystic or pustular acne?___
Do you have urgent, bright, or foul smelling stools?___
Does your menstrual blood contain stringy tissue or mucus?___

Are you prone to yeast infections and vaginal itching?___
Do your joints ache, especially with movement?___
Are you overweight?___
Do you have a wet, slimy tongue?___

Damp Heat
Do you have signs of heat and/or dampness as indicated above?___
Do you have foul smelling yellow, or greenish vaginal dischargre?___
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?___

Cold Uterus
Do you fit the kidney Yang deficiency category?___
Do you fall into the blood stasis pattern?___
Does your lower abdomen feel cooler to the touch than the rest of your trunk?___