Gynecology/Obstetric/Fertility Intake

Please describe your menses:

Age when menses began _____ Date of your last menstrual period (LMP) _____

What is cycle length, if regular (i.e. does your period usually come on Day 28 or Day 30, for example, or a range such as Day 24-Day 28)?
Day _____ or Range _____

If menses is irregular, please describe it (i.e. is your Day One unpredictable, do you skip months altogether, etc): _____

_____

Do you have ovulatory symptoms? _____ yes _____ no

Please circle which symptoms you experience: breast tenderness, irritability, increased libido, acne outbreak, headache/migraine, spotting, mittelschmerz (feel your ovary twinge) or other not listed: _____

Do you see cervical fluid at ovulation? _____ yes _____ no
If yes, is the amount of flow scant, the right amount, or copious (Please circle)

Do you have premenstrual tension? Please circle which symptoms you experience: irritability, anger, depression, sadness, bloating, backache, cramping, bowel changes, or other not listed: _____

How many days do you normally bleed for? _____

Are your periods painful? Do you have cramping in the beginning _____ yes
the middle _____ yes, or the end _____ yes (leave blank if no)

Do you have a backache in the beginning _____ yes,
the middle _____ yes, the end _____ yes (leave blank if no)

Please describe how the flow starts out, what middle is like, and what it's like as it tapers off:

Color (light red, red, light brown, brown, light purple, purple, for example)

Color of blood at beginning _____
Color of blood in the middle _____
Color of blood as it tapers off _____

Are there clots in the beginning _____ yes _____ no
Are there clots in the middle _____ yes _____ no
Are there clots in the end _____ yes _____ no

How heavy or light is the flow?

Beginning: _____ heavy _____ normal _____ light
Middle:_____ heavy _____ normal _____ light
End: _____ heavy _____ normal _____ light

Do you have to medicate during your period for pain? If so, what do you take?
_____

Date of last Pap smear _____ What was result? _____ normal _____ abnormal. If abnormal do you know what Stage/Grade?: _____

Have you ever been diagnosed with uterine fibroids or polyps? _____ yes _____ no
When were you diagnosed: _____
Have your fibroids or polyps been treated? Please describe _____
_____

Have you ever been diagnosed with endometriosis? _____ yes _____ no
When were you diagnosed: _____
Has your endometriosis been treated? _____ yes _____ no
Please describe where they saw lesions:
_____

Have you been diagnosed with PCOS? _____ yes _____ no
When were you diagnosed: _____
Has your PCOS been treated _____ yes _____ no
Please describe _____

Have you been treated for a STD? _____ yes _____ no
Which one? _____
When were you diagnosed: _____

Have you been diagnosed with HPV? _____ yes _____ no
When were you diagnosed? _____
Were you treated for HPV _____ yes _____ no
What was treatment? Acid application/ cervical cauterization / conization / other:
_____

Have you ever had PID? _____ yes _____ no
What year _____

Medication: Please describe forms of birth control and when taken:

1. _____ from _____ to _____

Please describe any side effects: _____
_____

2. _____ from _____ to _____

Please describe any side effects: _____
_____

Have you used Natural Family Planning? _____ yes _____ no
from _____ to _____

How many pregnancies have you had? _____

How many children do you have? _____

How many terminations have you had (if any)? _____

How many miscarriages have you had (if any)? _____

1st time: At what week did you miscarry _____
2nd time: At what week did you miscarry _____
3rd time: At what week did you miscarry _____

If more than 3 times please describe your recurrent miscarriage history_____
_____

How many times has a D&C been performed? _____
Do you have uterine scar tissue from your D&C (s)_____ yes _____ no

Do you get yeast infections regularly? _____ yes _____ no
Have you been able to connect them to anything? If so, what _____
_____

Do you get bladder infections regularly? _____
Have you been able to connect them to anything? If so, what _____
_____

Do you have troubling chronic vaginal discharge that is green or yellow and has an odor? _____
yes _____ no
Has it been diagnosed as Bacterial Vaginosis or some other infection? _____ yes
_____ no

Do you have Genital Herpes? _____ yes _____ no
If yes, for how long have you had it? _____
How often do you have outbreaks? _____ often _____ rare
Have you been able to connect them to anything? If so, what _____
_____

Have your fallopian tubes been evaluated medically? _____ yes _____ no
What were the results? Open, Both are blocked, Right is blocked, Left is blocked (Please circle)
Have you had any tubal operations? _____ yes _____ no
What was outcome? _____

If trying to conceive please answer the following section:

Do you have a single partner with whom you have been trying
to conceive? _____ yes _____ no
If so, for how long? _____

How would you describe your sex drive? _____ high _____ normal _____ low

Do you use vaginal lubricants such as PreSeed: _____ yes _____ no

Are you more than 20% over your ideal body weight? _____ yes _____ no

Are you more than 20% below your ideal body weight?_____ yes _____ no
Do you have a stressful occupation? _____ yes _____ no
Do you exercise regularly? _____ yes _____ no

Have you had a fertility workup? _____ yes _____ no
When was this workup done? _____
What is your infertility diagnosis? _____ Unknown etiology _____ yes _____ no
_____
_____

Have you had further workups since the one listed above? _____ yes _____ no
If so, when was this workup done? _____

Have you done Ovulation Predictor (OPK) tests? What day do you ovulate typically ?
_____
Have you tracked your basal temperature? _____ yes _____ no
Does your temperature rise at the appropriate time _____ yes _____ no
What temperature readings did you typically get? _____ first half of cycle
_____ second half of cycle

Do you know your AMH number? If so, please list it here: _____
Do you know your LH/FSH/Estradiol numbers? If so, please list it here:
LH_____Day 3 FSH_____ Estradiol_____
Do you know your Antral Follicle Count? If so please list it here:_____

Have you had immunological testing done? _____ yes _____ no
What were the results if positive? _____

What were your partner's results? If a man please describe issues with count, motility, or morphology _____
_____

Fertility Treatments/What treatments have you had so far?

Have you ovulation therapy treatment? _____ yes _____ no
What drugs did they use _____
For how long _____
What was outcome? _____

IUIs. Please list how many IUIs you have had and what outcome was:

	Date	Medicated or Unmedicated	Follicle #	Result

1. _____
Who was Doctor/Name of Clinic _____
2. _____
Who was Doctor/Name of Clinic _____

3. _____
Who was Doctor/Name of Clinic _____

4. _____
Who was Doctor/Name of Clinic _____

5. _____
Who was Doctor/Name of Clinic _____

6. _____
Who was Doctor/Name of Clinic _____

IVFs. Please list how many IVFs you have had and what outcome was:

1. Date: _____
Protocol:_____
Follicles Retrieved #_____
Follicles That Fertilized #_____
When Transferred? Day 3_____yes_____no
Day 5_____yes_____no
Transferred after genetic testing?_____yes_____no
What Stage when transferred? Morula?_____yes_____no
Blastocyst?_____yes_____no
Did you do ICSI?_____yes_____no
How Many Transferred? _____
Result? _____positive _____neg
Did you go on to live birth or miscarriage? _____
If miscarriage at what week?_____

Who was Doctor/Name of Clinic_____

2. Date: _____
Protocol:_____
Follicles Retrieved #_____
Follicles That Fertilized #_____
When Transferred? Day 3_____yes_____no
Day 5_____yes_____no
Transferred after genetic testing?_____yes_____no
What Stage when transferred? Morula?_____yes_____no
Blastocyst?_____yes_____no
Did you do ICSI?_____yes_____no
How Many Transferred? _____
Result? _____positive _____neg
Did you go on to live birth or miscarriage? _____
If miscarriage at what week?_____

Who was Doctor/Name of Clinic_____

3. Date: _____
Protocol:_____
Follicles Retrieved #_____
Follicles That Fertilized #_____
When Transferred? Day 3_____yes_____no
Day 5_____yes_____no
Transferred after genetic testing?_____yes_____no
What Stage when transferred? Morula?_____yes_____no
Blastocyst?_____yes_____no
Did you do ICSI?_____yes_____no
How Many Transferred? _____
Result? _____positive _____neg
Did you go on to live birth or miscarriage? _____

If miscarriage at what week?_____

Who was Doctor/Name of Clinic_____

4.. Date: _____
Protocol:_____
Follicles Retrieved #_____
Follicles That Fertilized #_____
When Transferred? Day 3_____yes _____no
Day 5_____yes _____no
Transferred after genetic testing?_____yes _____no
What Stage when transferred? Morula?_____yes _____no
Blastocyst?_____yes _____no
Did you do ICSI?_____yes _____no
How Many Transferred? _____
Result? _____positive _____neg
Did you go on to live birth or miscarriage? _____
If miscarriage at what week?_____

Who was Doctor/Name of Clinic_____

Pregnancy & Childbirth:
What was pregnancy like with Child #1? _____
What was delivery like? _____
_____
How was your postpartum recovery? _____
Did you have Postpartum Depression _____ yes _____ no
Did you have Postpartum Psychosis _____ yes _____ no
Did you breastfeed? _____ yes _____ no
Did you have trouble attempting to breastfeed? _____ yes _____ no
What problems did you have with breastfeeding. Please describe: _____
_____

What was pregnancy like with Child #2? _____
What was delivery like?_____
_____
How was your postpartum recovery? _____
Did you have Postpartum Depression_____yes _____no
Did you have Postpartum Psychosis _____yes _____no
Did you breastfeed?_____yes _____no
Did you have trouble attempting to breastfeed? _____yes _____no
What problems did you have with breastfeeding. Please describe:_____
_____

What was pregnancy like with Child #3? _____
What was delivery like? _____
_____
How was your postpartum recovery?_____
Did you have Postpartum Depression_____yes _____no
Did you have Postpartum Psychosis _____yes _____no
Did you breastfeed? _____yes _____no
Did you have trouble attempting to breastfeed?_____yes _____no
What problems did you have with breastfeeding. Please describe:_____
_____

SERENITY
HOLISTIC HEALTH

Patient Health History

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

Date of Birth: _____/_____/_____ Age: _____ Domestic status: S M D W

Address:_____City:_____State:_____Zip:_____

Email:_____ Phone:_____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

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.

1. When and where did you last receive health care? _____

For what reason? _____

2. Please identify the health concerns that have brought you in for treatment in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

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

_____

_____

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

_____

_____

_____

5. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

6. Do you have any infectious diseases? Y N If yes, please identify: _____

7. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ Time of maximum weight? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past): Ulcers

Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Period: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # Days Period Lasts: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past): Hypothyroid

Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

How did you hear about us? _____

Would you like to receive our email newsletter? _____

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The clinical data gathered in practice, without names, may be used for statistical data and research. We are HIPPA compliant to protect your privacy. According to federal policy, we need your written consent for the following:

Do we have permission to make appointment confirmation calls? Yes No

If yes, what number(s) should we call?

_____(home, work, cell) Are we allowed to leave a message? Yes No

PATIENT SIGNATURE _____ Date_____

(Or Patient Representative)

Indicate relationship if signing for patient _____

OFFICE SIGNATURE _____ Date_____

Serenity Holistic Health, LLC

Cancellation Policy

Failure to attend appointments creates considerable delay in the provision of care for yourself, and blocks access to care for other patients in need.

In order to encourage appropriate use of our service and to promote accessibility, kindly observe our 24-hour cancellation policy. **If you cancel an appointment within 24 hours of the scheduled appointment time, or if you miss an appointment, you will be subject to a charge up to the value of your appointment.** If the appointment was reserved with a gift certificate the certificate will be forfeited.

I acknowledge and agree to the cancellation policy.

PATIENT SIGNATURE _____ Date_____

(Or Patient Representative)

Indicate relationship if signing for patient _____

OFFICE SIGNATURE _____ Date_____

Serenity Holistic Health, LLC