Wise Wellness Center Fertility Intake

Name(First Middle Last)_____ Date:____/____/_____
Date of Birth____/____/_____ Age_____ Gender: M/F Marital Status: S M D W
Address:_____City_____State_____Zip_____
Phone: (_____)_____-_____ Email:_____
Emergency Contact: (Name)_____Relationship?_____Phone (___)_____-_____
Occupation?_____Do you exercise regularly? Y/N?
Alcohol/CaffeineNicotineUse_____
Have you received Acupuncture in the past? Y/N If yes, when?_____
Do you have any reason to believe you may be pregnant? Y/N If yes, how far along?_____
Do you have any infectious diseases? Y/N If yes, please identify?_____
Are you taking any medication, supplements or vitamins ? Y/N If yes, please list_____
_____
Do you have any allergies:_____
Are you taking a blood thinner such as coumadin or warfarin? Y/N?
Are you on Steroids? Y/N?
Do you have a pacemaker? Y/N?
Do you suffer from a seizure disorder? Y/N?
Are you taking medication for high blood pressure? Y/N?
Current Weight_____lbs Current Height_____ft_____in Current Blood Pressure_____/_____

Are you currently, or have you in the past, experienced any of these symptoms: Circle if current condition, underline if <u>past</u>

<u>Emotions</u>
Anxiety
Nervousness
Palpitations
Stress
Panic attacks
Depression

<u>Energy and Immunity</u>
Fatigue
Chronic Fatigue
Chronic Infections
Allergies
Headaches

<u>Respiratory/HEENT</u>
Frequent colds/flu
COPD
Emphysema
Asthma
Sinus Issues
Ear Ringing

<u>Endocrine</u>
Thyroid Conditions
Hashimoto's Disease
Adrenal Fatigue
Addison's Disease
Diabetes
Hypoglycemia

<u>Gastrointestinal</u>
Ulcer
GERD
IBS
Chrons
Ulcerative Colitis
Gallbladder disease
IBD

<u>Genitourinary</u>
UTI's
Kidney disease
Kidney Stones
Frequent Urination

<u>Female Reproductive</u>
Painful Menses
Irregular Cycles
Endometriosis
Ovarian Cysts
Infertility
Menopause
Night Sweats
Spontaneous Sweats

<u>Cardiovascular</u>
Heart Disease
High Cholesterol
High Blood Pressure
Stroke
Irregular Heartbeat

<u>Muskuloskeletal</u>
Neck/Shoulder Pain
Low Back Pain
Muscle Spasm/cramps
Leg Pain/Arm Pain
Joint Pain
Upper/Mid Back Pain
Arthritis/Osteoarthritis

<u>Neurological</u>
Dizziness/Vertigo
Seizures/Epilepsy
Numbness/Tingling
Alzheimers
Parkinson's
Migraines

<u>Other</u>
Anemia
Cancer
Eczema/Hives

<u>Male Reproductive</u>
Prostate Problems
Testicular Pain/Swelling
Sexual Difficulties
Frequent Urination

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How often do you have a bowl movement? ____per/day. (circle one) generally watery, loose, soft, well-formed, hard, pellets, difficult to evacuate, incomplete feeling, do they vary from loose to hard?

How often do you urinate?_____/day, At night?____ If at night, what time do you wake to urinate?___

Do you crave: (circle one) Beverages that are: Iced, Cold, Room temp., Warm, Hot?

Do you generally feel: (circle one) cold or run warm? Do you have cold hands and feet? Y/N

What time do you go to bed?_____What time do you wake up?_____ Do you wake rested? Y/N?

Your energy from a scale of 0-10, 0 being no energy and 10 your best:
after you wake up? _____ 12-3pm?_____ 5-7pm_____ 7-9pm_____?

Current Stress Level 0 being no stress, 10 being the worst you can imagine?_____

Any significant increase or decrease in appetite in last 6 months? Y/N?

Any Gas, Acid-reflux, GERD, Bloating, Abdominal pain? Y/N? If Yes, circle all that apply

Are you a Smoker? Y/N? If so, How long?_____ How many cig/packs per day?_____

Menses: Age of first menses?____# of days of menses?_____Length of cycle?_____Type of Birth Control?_____# of Pregnancies?____# of Miscarriages?___# of abortions?___# of Live Births?_____

Date of last two menstrual periods____/____/____ and ____/____/____

Are your periods regular?_Y/N? Do you bleed between periods? Y/N?

Do you experience premenstrual symptoms? (circle all that apply) Irritability, anxiety, weepiness, depression, breast distention, bloating, fatigue, headaches, other (please list)_____

Pelvic/pain cramps:(circle all that apply): None during menses, Before menses, after menses, at mid cycle, during intercourse, with bowl movements, with urination, causes you to miss work, cause you to miss usual activities,

Pelvic pain/cramps are: (circle one) Mild, moderate severe
(circle one) worsening, improving, no change, in midline, on right side, on left side.

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Do you have or have you had: Circle all that apply

Chlamydia	Endometriosis	Pelvic Adhesions	Cervicitis	Genital herpes	Appendicitis	Colitis or enteritis	Uterine Firboids
Recurrent vaginitis	Abnormal pap smear	Gonorrhea	Syphilis	Abnormal uterus shape	Ovarian cysts	Gential warts	Cryo (freezing of cervix)
Toxoplasmosis	Cytomegalovirus	Trichomonas	Pelvic infection				

Pregnancy History:

Date:	Miscarriage	Ectopic	Abortion	Months to conceive?	Infertility treatment	Weight and Sex	C-section	Complications?
1								
2								
3								
4								

Contraceptive Use:

Type:_____From when to when_____/____/ to ____/____/Reason discontinued?

_____

Type:_____From when to when_____/____/ to ____/____/Reason discontinued?

_____

Type:_____From when to when_____/____/ to ____/____/Reason discontinued?

_____

Operations and Hospitalizations:

Date:_____Diagnosis_____

Date:_____Diagnosis_____

Date:_____Diagnosis_____