

Fertile Lifestyle

7850 Mission Center Court, Suite 207, San Diego, CA 92108

The following is a confidential questionnaire to determine the best possible approach and treatment plan for you. Please take the time to complete this information. Thank you.

A. Personal Information

Name: _____

Sex: Female _____ Male _____

Age: _____

Date of Birth: _____

Home Address: _____

Place of Birth: _____

Social Sec. Number: _____

Home Phone: _____

Occupation: _____

Work Phone: _____

E-Mail Address: _____

Insurance Information

Name of Company: _____

Company's address: _____

Claim number: _____

Who can we thank for your referral? _____

When were you last seen by a medical doctor?

Date: _____

Attending physician: _____

Reason for visit: _____

Diagnosis: _____

Have you ever been treated by acupuncture or Chinese medicine? If yes, what is the name and address of your practitioner: _____

B. Medical History

What are you health complaints at this time, both medical and psychological?

Indicate the accidents, injuries, and hospitalizations you have had:

- | | Date or age |
|----------|-------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

What other health problems have you had? _____

C. Family History:

In your family is there any history of:

	Yes	No	Who
Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____
Diabetes	_____	_____	_____
Other (): _____	_____	_____	_____

List any prescribed medication(s) that you are presently taking?

Medication	Dosage	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

What vitamins and/or supplements do you regularly take?

Vitamin/supplement	Dosage	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Do you drink coffee or black tea? If so, how often? _____

Do you smoke cigarettes? If so, how many? _____

Do you drink alcohol? If so, how often? _____

Do you exercise? If so, how often? _____

D. In the last 6 months, which of the following symptoms have you experienced?

	Never	Sometimes	Often
Excessive appetite	_____	_____	_____
Loose stools or diarrhea	_____	_____	_____
Digestive problems	_____	_____	_____
Vomiting	_____	_____	_____
Belching or burping	_____	_____	_____
Heartburn	_____	_____	_____
Feeling of retention of food In the stomach	_____	_____	_____
Tendency to be "obsessive" In work, relationships	_____	_____	_____
Cough	_____	_____	_____
Shortness of breath	_____	_____	_____
Decreased sense of smell	_____	_____	_____
Nasal problems/	_____	_____	_____
Skin problems	_____	_____	_____
Bronchitis	_____	_____	_____

	Never	Sometimes	Often
Colitis or diverticulitis	_____	_____	_____
Constipation	_____	_____	_____
Hemorrhoids	_____	_____	_____
Recent use of antibiotics	_____	_____	_____
Low back pain	_____	_____	_____
Knee problems	_____	_____	_____
Hearing impairment	_____	_____	_____
Ringing in the ears	_____	_____	_____
Kidney stones	_____	_____	_____
Decreased sex drive	_____	_____	_____
Hair loss	_____	_____	_____
Urinary problems	_____	_____	_____
Insomnia	_____	_____	_____
Heart palpitations	_____	_____	_____
Nightmares	_____	_____	_____
Mentally restless	_____	_____	_____
Laughing for no reason	_____	_____	_____
Angina pains	_____	_____	_____
Eye problems	_____	_____	_____
Jaundice (yellow skin/eyes)	_____	_____	_____
Hepatitis	_____	_____	_____
Difficulty digesting oily foods	_____	_____	_____
Gallstones	_____	_____	_____
Light colored stools	_____	_____	_____
Soft or brittle nails	_____	_____	_____
Easily angered or agitated	_____	_____	_____
Difficulty making plans or decisions	_____	_____	_____
Spasm or twitching of the muscles	_____	_____	_____
Fatigue	_____	_____	_____
Edema	_____	_____	_____
Blood in the stools	_____	_____	_____
Black tarry stools	_____	_____	_____
Easily bruised	_____	_____	_____
Difficult to stop bleeding	_____	_____	_____
Asthma	_____	_____	_____
Tendency to catch colds easily	_____	_____	_____
Intolerance to weather changes	_____	_____	_____
Allergies	_____	_____	_____
Hayfever	_____	_____	_____
Tendency to faint easily	_____	_____	_____
High blood pressure	_____	_____	_____
High Cholesterol levels	_____	_____	_____
Sudden weight loss	_____	_____	_____

Do you regularly experience pain?

	Never	Sometimes	Often
Chest pain	_____	_____	_____
Sciatic pain	_____	_____	_____
Abdominal pain	_____	_____	_____
Headaches	_____	_____	_____
Other: _____	_____	_____	_____

FOR WOMEN

How often do you experience the following:

	Never	Sometimes	Often
Premenstrual pain or discomfort	_____	_____	_____
Menstrual pain or discomfort	_____	_____	_____
Breast swelling or pain	_____	_____	_____
Irregular menstrual cycle	_____	_____	_____

	Yes	No
Are you pregnant?	_____	_____
Have you ever been pregnant?	_____	_____
If so, how many births?	_____	
How many spontaneous abortions?	_____	
How many therapeutic abortions?	_____	

When did you have your last gynecological exam? _____

Results: _____

When did you have your last pap smear? _____

Results: _____

What method of birth control do you use, if any? _____

Is there other information helpful, in this area? _____

FOR MEN

	Yes	No
Do you have prostate problems?	_____	_____
Do you have painful or burning urination?	_____	_____
Do you have pain or coldness in the genital area?	_____	_____

Other: _____

Are there any other complaints or symptoms that you feel are important which have not been covered by this questionnaire? _____

