Fertile Lifestyle and Integrative Medicine

3675 Ruffin Road, Suite 135, San Diego, CA 92123

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: _____________**
_______________________________________ **Home Phone: ______________**
Social Sec. Number: ___________________ **Work Phone: ______________**
Occupation: ____________________________ **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	_____	_______	______
Irrregular 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? ____
____
____
____