

Day 0
INITIAL CONSULTATION

DATE: ___/___/___

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ - _____ WORK PHONE: () _____ - _____

CELL PHONE: () _____ - _____ E-MAIL _____

EMPLOYER _____ SPOUSE EMPLOYER _____

DATE OF BIRTH: ___/___/___ AGE: _____ SEX: _____

MAIN HEALTH COMPLAINTS:

1) _____

2) _____

3) _____

Which of the above conditions is the worst? _____

What medications are you taking for it? _____

Do you have health insurance? Y N Insurance Provider _____

PLEASE LIST M.D. NAME AND CONTACT NUMBER:

PRIMARY PHYSICIAN: _____ () _____ - _____

OBGYN: _____ () _____ - _____

RE: _____ () _____ - _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

___NEWSPAPER: Which one? _____ ___LECTURE: Topic _____

___INTERNET: Search Engine _____ Ad _____

___REFERRAL: Patient _____ Doctor _____ Other _____

___HEALTH FAIR/FARMER'S MARKET (circle one): Location _____ Gift Certificate: Y N

___OTHER: _____

Patient Information Sheet

Current Diagnosis

Patient Name: _____ Age: _____ Years trying to conceive: _____

Number of	
Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Failed IUI's	
Failed IVF's	

Occupation: _____

Hobbies / Interests: _____

Husband: _____ Occ: _____ Age: _____

Male Factor: _____

Children: Name(s)/Age(s): _____

Important Clinical Notes: _____

Western Diagnosis for Infertility: _____

OB/GYN: _____ **R.E.** _____

Major Fertility Signs and Symptoms: _____ Cycle Days _____ Days of Bleeding

Reg. / Erratic: _____ Clotting: _____ Spotting: _____

PMS Signs: _____ Pain: _____

Cervical Mucous: _____ Ovulation: _____

Color of Blood: _____ Notes: _____

Acupuncturist: _____ Date: _____

Menstrual and Fertility Update - *At a Glance*

Patient Name: _____									
Describe your current menstrual cycle for each of the questions:		Cycle # 1	Cycle # 2	Cycle # 3	Cycle # 4	Cycle # 5	Cycle # 6	Cycle # 7	Cycle # 8
# of days in your Menstrual Cycle									
What cycle day did you ovulate?									
Number of days <u>above</u> 98°	Before Ovulation								
	After Ovulation								
Number of days <u>below</u> 97°	Before Ovulation								
	After Ovulation								
Did you have abundant, stretchy, clear cervical mucus? - If not what did you have?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you experience spotting or cramping at ovulation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What symptoms of PMS did you experience?									
Did you have clotting? Size of clots - Dime? Nickel? Quarter?									
Did you have menstrual pain?									
How many days did you bleed?									
Did you have spotting prior to cycle day one?									
How long would it take for you to soak a tampon/pad?									
Medications and Fertility Drugs									

History of Procedures / Surgeries:

Doctor's Notes: