BOSTONIVF

Acupuncture Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of the information on this form will be kept absolutely confidential, unless you specifically authorize its release. If you have questions, please ask. If there is anything you wish to discuss which is not asked on this form, please note it in the "Other" section at the end. Thank you.

Name:_____

Street:_____ City: _____

State: _____ Zip: _____

Phone: - please indicate which is your preferred contact number

Home:_____Mobile: _____

Gender: ____ Date of Birth: _____

Email:_____

Occupation: _____

Emergency Contact: _____

Emergency Contact Phone: _____

How did you hear about us? _____

Have you been treated with acupuncture or oriental medicine before? _____

If yes, by whom? _____ For what condition? _____

Payment is due at the time of the treatment. If you have any questions about our payment policy, please ask.

Main Problem

What is the main problem you would like us to help you with?

_____
_____
_____

How long ago did this problem begin (be as specific as possible)?

_____

Has this problem been diagnosed by an M.D.? If yes, what is your diagnosis?

_____

What kinds of treatment have you tried for this problem?
_____
_____

What other problems would you like us to address? _____
_____
_____
_____

Medical History

Significant Illnesses/Surgeries/Allergies:
_____
_____
_____
_____
_____

Medicines taken within the last two months (including vitamins, herbs, etc.):
_____
_____
_____

Family Health History

Do any of your parents, grandparents, siblings or children suffer from any of the conditions below?

Diabetes	Cancer	High Blood Pressure	Heart Disease
Stroke	Seizure Disorders	Asthma	Allergies

Please indicate if you have had any of the following in the last three months:

General

How is your body temp in general – hot , cold or neutral? _____
Night sweats or hot flashes? _____ _____
Do you spontaneous sweat? _____

Are you excessively hungry or thirsty? _____
How much water/fluid do you drink per day? _____
Do you notice unusual tastes in your mouth? Bitter, sour, metallic or burnt? _____
_____

Do you smoke? If yes,how many per day? _____
How much coffee, tea, or cola do you drink per week? _____
How much alcohol do you drink per week? _____
Do you exercise? If yes, average hours per week?_____

Skin and Hair

☐ Rashes
☐ Itching
☐ Dandruff
☐ Acne
☐ Loss of Hair
☐ Abnormal Hair Growth
☐ If yes to abnormal hair growth, do you use hair removal treatments?

Head, Eyes, Ears, Nose and Throat

☐ Headaches
☐ Cataracts
☐ Ringing in the Ears
☐ Grinding Teeth
☐ Sinus Problems
☐ Sore Throat
☐ Poor Hearing
☐ TMJ Disfunction
☐ Migraines
☐ Earaches
☐ Spots before the Eyes
☐ Sores on Lips or Tongue

Cardiovascular

☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Cold Hands or Feet
☐ Blood Clots
☐ Low Blood Pressure
☐ Dizziness
☐ Swelling of Hands
☐ Phlebitis
☐ Chest Pain
☐ Fainting
☐ Swelling of Feet / Hands
☐ Difficulty Breathing

Respiratory

☐ Cough – with/without phlegm?
☐ Pneumonia
☐ Asthma
☐ Bronchitis
☐ Difficulty Breathing when Lying Down
☐ Pain with Deep Breath

Gastrointestinal System

☐ Nausea ☐ Vomiting ☐ Heartburn
☐ Constipation ☐ Diarrhea ☐ Belching
☐ Black Stools/ Blood in Stools ☐ Gas / Bloating ☐ Indigestion
☐ Bad Breath ☐ Rectal Pain/Itching ☐ Hemorrhoids
☐ Laxative Use ☐ Abdominal Pain, please describe location: _____

How often do you have a bowel movement? _____
What is the consistency of the stools, normally? (soft, hard, formed, unformed, pebble like)?
_____

Urogenital System

☐ Painful Urination ☐ Frequent Urination ☐ Blood in Urine
☐ Urgency to Urinate ☐ Unable to Hold Urine ☐ Kidney Stones
☐ Decrease in Flow ☐ Impotency ☐ Frequent UTI's

How many times per day do you normally urinate? _____

Do you wake up at night to urinate? Yes / No How often? _____

Is your urine especially pale, dark or cloudy? _____

Musculoskeletal System

☐ Joint Pain ☐ Muscle Pain ☐ Bone Pain

Please describe the exact <u>location</u> and nature (sharp, dull, achy, stabbing, hot, cold, etc.) of the pain-
_____
_____
_____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance
☐ Areas of Numbness ☐ Lack of Coordination ☐ Poor Memory
☐ Insomnia ☐ Depression ☐ Anxiety

How many hours of sleep do you get per night? _____ Are you rested in the morning? _____

Have you ever been treated for emotional issues? When, for how long? With medication?

_____

Reproductive and Gynecological System

__ Age at first menses __ Length of Period (days) __ Date of first day of last menstrual period

__Pain with Menstruation __ Vaginal Discharge (color?) __ Mid-Cycle Pain

__Days in between cycles __ Irregular Periods __ Vaginal Sores

Is your menstrual flow especially heavy or light? _____

Is the color of your menstrual blood especially light, dark or brown? _____

Are there clots in your bleeding? _____

Do you experience any pre-menstrual or menstrual changes to your body or psyche?
_____

Date of last PAP smear- _____
Any abnormal issues? _____

Do you practice birth control? _____ What type, how long? _____

Have you had any sexually transmitted diseases? _____

If you are menopausal:
Date of onset of menopause- _____ Age _____

Any other gynecological or reproductive problems? _____
_____

Fertility:
__ Number of pregnancies __ Number of births __ Premature births

__ Caesarian Sections __ Miscarriages __ Abortions

How long have you been trying to get pregnant? _____

Have you been diagnosed with any fertility related problems? _____

What fertility treatments have you been through? Ex. IUI, IVF, Clomid
_____
_____

Is this a Donor Egg cycle?_____ Fresh or frozen?_____
Does your partner have any reproductive or general health problems?_____
_____
What age is your partner?_____

Male Factor::
Issues with sperm motility , morphology, &/or count ?_____
Are you using ICSI or PGD?_____