

The Texas Center for Reproductive Acupuncture



Health History Questionnaire

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Important: The information on this form will help your acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

General Patient Information (All of the information provided is strictly confidential – see permission to share medical information section)

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Primary Telephone Number: _____ Alternative Phone # _____

E-Mail: _____ Today's Date ____ / ____ / ____ Clinic Location: Austin / San Antonio

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

Name of your
Ob/Gyn: _____
Reproductive Endocrinologist: _____
Midwife: _____

Menstrual Cycle
Age menstruation began: _____
How long have you been trying to get pregnant? _____
(please circle one) My periods are:
a) Like clockwork
b) Somewhat regular
c) Erratic

Number of days in a typical menstrual cycle: _____

If your cycle is erratic:
Shortest # of days in cycle: _____
Longest # of days in cycle: _____

Menstrual bleeding tends to be:
a) Light b) Normal c) Heavy

On what cycle day do you typically ovulate? _____

During ovulation, is your cervical mucus clear, stretchy and abundant?
 Yes No

If not all three of these, describe:

Is there clotting with your period?
 Yes No

Do you have spotting before or between periods? Yes No

Do you regularly experience PMS?
 Yes No

(Circle which PMS symptoms you get)
Breast tenderness - Diarrhea - Acne
Bloating - Constipation - Back Pain
Food Cravings - Dizziness - Fatigue
Headache or Migraine - Mood Swings

Previous Gynecological Surgeries - Check any surgical procedure that you have had

- | | |
|--|---|
| <input type="checkbox"/> Dilation & Curettage (D&C) | <input type="checkbox"/> Laparoscopy (uterine fibroids) |
| <input type="checkbox"/> Falloposcopy | <input type="checkbox"/> Mymectomy |
| <input type="checkbox"/> (HSG) Hysterosalpingogram | <input type="checkbox"/> Neosalpingostomy |
| <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Tuboplasty |
| <input type="checkbox"/> Laparoscopy (endometriosis) | <input type="checkbox"/> Other(s): _____ |
| <input type="checkbox"/> Laparoscopy (ovarian cysts) | |

Previous Diagnostic Assessments - Check any diagnosis received by your OB/GYN or Fertility Doctor

- | | |
|---|--|
| <input type="checkbox"/> Advanced Maternal Age | <input type="checkbox"/> Luteal Phase Defect |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Menorrhagia |
| <input type="checkbox"/> Anovulation | <input type="checkbox"/> Ovarian Cyst (single) |
| <input type="checkbox"/> Anti-sperm Antibodies | <input type="checkbox"/> Ovarian Cyst (multiple) |
| <input type="checkbox"/> Autoimmune Oopharitis | <input type="checkbox"/> Ovarian Hyperstimulation Syndrome (OHSS) |
| <input type="checkbox"/> Cervical Stenosis | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |
| <input type="checkbox"/> Clotting with Period _____ | <input type="checkbox"/> Phospholipid Antibodies |
| <input type="checkbox"/> Delayed Cycles ____ - ____ Days | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) |
| <input type="checkbox"/> Menstrual Pain (mild) | <input type="checkbox"/> Premature Menopause |
| <input type="checkbox"/> Menstrual Pain (moderate) | <input type="checkbox"/> Premature Ovarian Failure (POF) |
| <input type="checkbox"/> Menstrual Pain (severe) | <input type="checkbox"/> Resistant Ovarian Syndrome |
| <input type="checkbox"/> Elevated FSH _____ | <input type="checkbox"/> Short Cycles ____ - ____ Days |
| <input type="checkbox"/> Endometriosis (mild, moderate, severe) | <input type="checkbox"/> Spotting between periods ____ - ____ Days |
| <input type="checkbox"/> Erratic Cycles ____ - ____ Days | <input type="checkbox"/> Unexplained Infertility |
| <input type="checkbox"/> Fallopian Tube Blockage | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Habitual Miscarriage | <input type="checkbox"/> Uterine Septum |
| <input type="checkbox"/> Hostile Cervical Mucus | <input type="checkbox"/> Other(s): _____ |
| <input type="checkbox"/> Hyperprolactinemia | |

List the Fertility Drugs you have taken: _____

Medications you use currently: _____

Have you been tested for chlamydia? Yes No - Results: Positive Negative

Personal and Contact Information

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Separated Divorced Widowed Partnered

Spouse's Name: _____ Spouse's Age: _____ Occupation: _____

Spouse's Place of Employment: _____

Has your husband/partner had a semen analysis? _____ Results: _____

In case of emergency, whom should we notify? _____ Relationship: _____

Contact Number: _____ Address: _____

How did you hear about our office? _____

General Health Information

Major Health Complaint(s). Other than your primary reproductive concerns, please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms

Additional Health Complaints / Symptoms

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Please explain how these conditions affect or impair your daily activities

Describe your symptoms when they are at their worst: _____

Are there any other complaints or conditions that you would like us to know about? _____

Medical Conditions and History (Check any conditions that you have had in the past, or are currently experiencing):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding or hemorrhage |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Irregular Pap Smear |
| <input type="checkbox"/> Other _____ | | | |

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Body Temperature (Kidney Organ System)

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Night sweating | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Strong thirst | |

Energy and Stamina (Lung and Kidney System)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Easily prone to illness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Frequent colds / flus / sinus | <input type="checkbox"/> Chronic allergies |

Blood Function (Liver, Heart and Spleen System)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Itchy or dry | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weak or brittle nails |

Heart Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Manic moods | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Severe shyness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rapid Heart Beating | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral valve prolapse |

Lung Function

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cigarette smoking |
| Allergies to <input type="checkbox"/> Mold <input type="checkbox"/> Cedar <input type="checkbox"/> Pet fur <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Oak <input type="checkbox"/> Hay Fever <input type="checkbox"/> Environmentally Sensitive | | | |

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? Yes No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gas | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Indigestion |

Stomach Function

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |

Bowel Function and Elimination (Intestinal Function)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty moving bowels | <input type="checkbox"/> I.B.S. or Colitis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Less than 1 BM/ Day | <input type="checkbox"/> Eating Disorder |

Accumulated Dampness

- | | | |
|---|---|---|
| <input type="checkbox"/> Mental fogginess | <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Edema in the legs |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Edema in the abdomen |
| <input type="checkbox"/> Poor mental focus | <input type="checkbox"/> Joint stiffness / ache | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Heaviness of the head, the limbs, or of the whole body | <input type="checkbox"/> Symptoms worsen in rainy weather | |

Liver and Gall Bladder Function

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Pain in the ribcage | <input type="checkbox"/> Acne |
| <input type="checkbox"/> All over body tension | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Heaviness in ribcage | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Chronic neck tension | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Shoulder tension | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Eye pain / dryness |
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Easily overwhelmed by stressful circumstances | | |

Please list any non-prescription or recreational drugs you currently take _____

Eyes (Liver Function)

- | | | | |
|--------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Red and irritated | <input type="checkbox"/> Near sighted | <input type="checkbox"/> Glaucoma |

Kidney and Urinary Bladder Function

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Broken / loose teeth | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips / buttocks | <input type="checkbox"/> Early graying of hair |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold knees | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Quick to fear / fright |

Urinary Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Reddish color | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination |
| <input type="checkbox"/> Dark Yellow | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Large amount | <input type="checkbox"/> UTI / Pain or burning |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Hesitancy |
| <input type="checkbox"/> Difficulty initiating the stream of urination | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Weak stream | |

Libido Function

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> High sex drive | <input type="checkbox"/> Diminished sex drive | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Fatigue following sexual activity | <input type="checkbox"/> Infertility | |

Fertility Stress Assessment

Managing stress effectively is an essential component of healthy reproduction. The more effectively stress is managed, the more your body and mind become relaxed, receptive and fertile.

How would you rate your current stress level? (1 being the least, 10 being the highest) 1 2 3 4 5 6 7 8 9 10

In what areas of your life do you feel the most stressed? Circle all that apply: Fertility process - Job/Career
Partner/Spouse relationship - Parents/Family - Financial - Friends - Other(s): _____

How does this stress impact your:

- Health: _____
- Thoughts about self: _____
- Thoughts about others: _____
- Feelings/Mood: _____
- Actions: _____

How would you describe your current level of hopefulness towards attaining your fertility goals?

(1 being the lowest feeling of hope, and 10 being the most hopeful) 1 2 3 4 5 6 7 8 9 10

What are your main source(s) of support? Spouse/Partner - Family - Friends - Workplace - Church
Support group - Therapist - God/Prayer - Myself (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? Massage therapy - Physical exercise
Meditation - Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Our clinic has a very skilled and highly trained counselor on site who offers professional support services. Circle each of the support services below that you think might be of interest:

Online support and discussion group - Live group support meetings - Fertility Retreats - Seminar Series

Medical Evaluation

I have been evaluated by a physician, OB/GYN, Reproductive endocrinologist for the condition being treated within the last twelve months.

Yes No

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information in each of the following areas.

1) The Texas Center for Reproductive Acupuncture is a multi-practitioner office. Each of the acupuncturists on our team is involved with every patient. During the course of your care with us, you may choose to schedule your visits with any of the acupuncturists on staff. Do you grant permission for your file and acupuncture records to be viewed and shared among all of the practitioners at The Texas Center for Reproductive Acupuncture? Yes No

2) Our office works closely with a very skilled and highly trained psychotherapist who directs our Emotional Support Services. Do you grant us permission to share the information in your file with our director of Emotional Support Services? Yes No

Is it OK for her to contact you to discuss the Support Services that are included in our programs? Yes No

3) Many of our patients are under the care of an OB/GYN, a Reproductive Endocrinologist, or a Fertility Specialist. In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your OB/GYN, Reproductive Endocrinologist and/or Fertility Specialist? Yes No

Patient Signature

Date