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? _____
_____
_____
_____