TCM – Female Medical History Form

CONFIDENTIAL

Please check boxes, circle or fill in where applicable

To assist in providing you with the best possible care, please fill in this form as accurately as you can. All of the information will be kept confidential in your patient file.

Today's Date: ____/____/_____
Month / Day / Year

Name: _____/_____/_____
Last Name *First Name* *Middle Initial*

Address: _____/_____/_____/_____
Apt#, Street *City* *Province* *Postal code*

Phone: *(home)* _____ Occupation: _____

Phone: *(work)* _____ Birth Date: _____/_____/_____
Month Day Year

Phone: *(cell)* _____ E-mail _____

How did you hear about acupuncture and Chinese Medicine being offered at this clinic?

_____

What concerns brought you into the clinic today: _____

What, if any, are your present symptoms: _____

Have you ever been treated with Traditional Chinese Medicine?
○ Yes: When: _____ ○ No

Are you currently utilizing any other forms of health care?
○ Yes:_____ ○ No

Are you currently taking any prescription or non-prescription drugs?
○ Yes:_____ ○ No

Are you currently taking vitamins, minerals or herbs?
○ Yes: _____ ○ No

Do you use the following? If so, how often? Cigarettes:_____ Alcohol:_____

Drugs: _____ Coffee: _____

How do you rate your energy level: /10 (10 being high and 0 low)

How do you rate your average stress level? (please circle one)

None Slight Moderate Severe

Is this normal for you? ○ Yes ○No

Please list any physical activity (what type / how often):

_____

_____

Have you ever been hospitalized and /or treated for any serious condition or surgeries?

○ Yes ○ No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

_____

_____

Do you have any of the following conditions or symptoms? (please check all that apply)

	Past	**Present**	**Comments**
High Blood Pressure	○	○	_____
Stroke	○	○	_____
Heart Condition	○	○	_____
Diabetes	○	○	_____
Circulation Problems	○	○	_____
Deep Vein Thrombosis	○	○	_____
Varicose Veins	○	○	_____
Pregnancy	○	○	_____
Miscarriage	○	○	_____
Abdominal Pains	○	○	_____
Digestive disorders	○	○	_____
Headaches	○	○	_____
Migraines	○	○	_____
Sleep Disorder	○	○	_____
Skin Problems	○	○	_____
Tumors / Cysts	○	○	_____
STI sexually transmitted infections	○	○	_____
Anemia	○	○	_____
Depression	○	○	_____
Allergies	○	○	_____
Asthma	○	○	_____
Infectious Diseases	○	○	_____

Head and Neck
○ Dizziness
○ Fainting
○ Neck Stiffness
○ Enlarged Lymph Glands
○ Headaches / Migraines
○ Other _____

Eyes
○ Blurred vision
○ Spots / Floaters
○ Eye Pain
○ Dry Eyes
○ Poor Night Vision
○ Red / burning or itchy
○ Other _____

Ears
○ Recurring Infections
○ Earaches
○ Ringing in ears
○ Wax Buildup
○ Reduced Hearing
○ Other _____

Nose and Throat
○ Bleeding Gums
○ Sinus infections
○ Hay Fever / Allergies
○ Recurring Sore Throat
○ Swollen Glands
○ Hard to Swallow
○ Bitter Taste in Mouth
○ Canker / Mouth Sores
○ Nose Bleeds
○ Dry Mouth
○ Frequent Thirst

Muscle and Joints
○ Joint Pain
○ Body Aches or Stiffness
○ Muscle Weakness
○ Numbness or Tingling
○ Backache or Knee Pain
○ Other _____

Respiratory
○ Wheezing / Asthma
○ Difficulty Breathing
○ Chronic cough
○ Coughing Phlegm
○ Coughing Blood
○ Frequent Colds
○ Other _____

Genital / Urinary
○ Pain/Itching of Genitalia
○ Genital Lesions/ discharge
○ Painful Urination
○ Frequent Urination
○ Urgent Urination
○ Urinary Incontinence
○ Excessive Urination
○ Scanty Urination
○ Blood in the Urine
○ Wake up to Urinate
○ Bedwetting
○ Kidney Stones
○ Increased Libido
○ Decreased Libido
○ Other _____

Cardio Vascular
○ Heart Palpitations
○ Rapid Heartbeat
○ Chest Pain or Tightness
○ Irregular Heartbeat
○ Poor Circulation
○ Swollen Ankles
○ Edema
○ Other _____

General
○ Cold Hands or Feet
○ Cold Nose
○ Aversion to Heat
○ Aversion to Cold
○ Chills
○ Recent Weight Changes
○ Fatigue
○ Poor memory

Skin
○ Hives
○ Rashes
○ Eczema
○ Psoriasis
○ Acne
○ Itchiness
○ Dryness
○ Mole or lump changes
○ Spontaneous Sweats
○ Hot Flushes / Fever
○ Bruise Easily
○ Fine Hair / Falling Out
○ Nails Break Easily
○ Other _____

Gastrointestinal
○ Nausea
○ Vomiting
○ Acid Reflux / Heartburn
○ Gas
○ Bloating
○ Abdominal Pains or cramping
○ Frequent Hiccups
○ Bad Breath
○ Poor Appetite
○ Ravenous Appetite
○ Hunger with no desire to eat
○ Loose or Soft Stools
○ Constipation
○ Alternate Loose /Constipation
○ Laxative Use
○ Black Stools
○ Blood in Stools
○ Mucous in Stools
○ Itchiness or Pain in Anus
○ Burning Anus
○ Rectal Pain
○ Anal Fissures
○ Hemorrhoids
○ Other _____

Sleep
○ Restful
○ Light
○ Hard to fall asleep
○ Wake up easily / early
○ Dream Disturbed
○ Nightmares
○ Heavy Sleep
○ Night Sweats
○ Hours of Sleep/night ___
○ Other _____

Emotions
○ Relaxed & Calm
○ Sad
○ Fearful
○ Depressed
○ Angry / Frustrated
○ Irritated easily
○ Anxious
○ Stressed
○ Over thinking / Worry
○ Forgetful
○ Manic
○ Impatient
○ Other _____

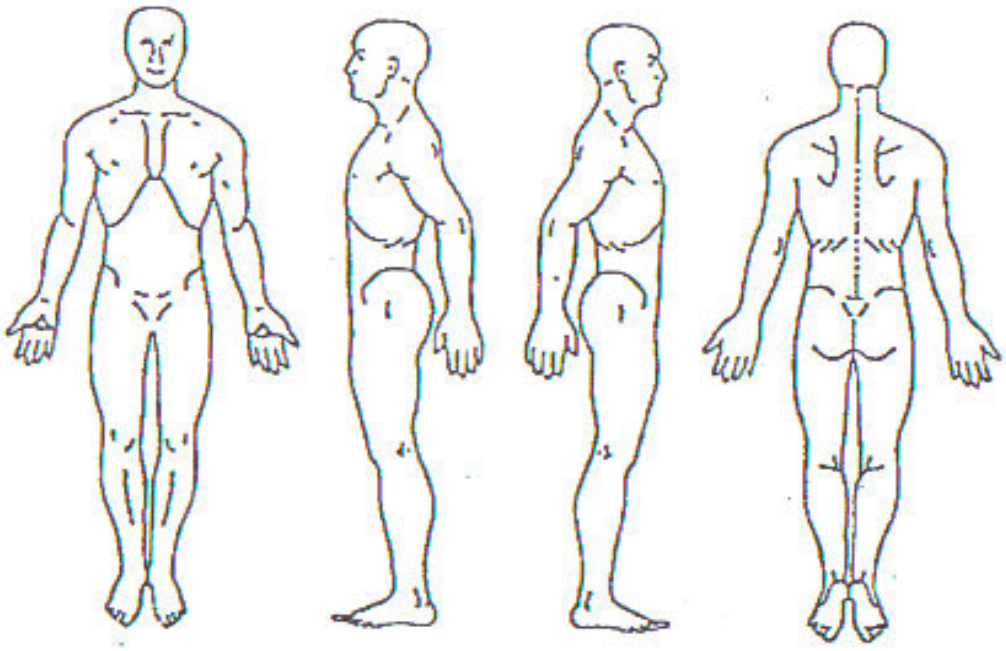
Please inform your TCM practitioner / acupuncturist if any of the following apply to you:

Haemophiliac	○ Yes ○ No	Epilepsy	○ Yes ○ No
Wear a pacemaker	○ Yes ○ No	Are you a vegetarian?	○ Yes ○ No
Have a serious heart or lung condition	○ Yes ○ No	Do you have surgeries scheduled?	○ Yes ○ No
If you are taking anticoagulant medications?	○ Yes ○ No	Are you pregnant or is there a chance you may be pregnant?	○ Yes ○ No

Do you have Chronic or Acute injuries? ○ Yes:_____ ○ No

Are you currently experiencing pain? ○ Yes: _____ ○ No

On the figures below, Please circle any areas of pain/concern:



Sensations / pain: Sharp _____ Burning ____ Dull ____ Aching ____ Shooting _____

Tingling _____ Numbness _____ Other _____

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

_____

What aggravates the pain? _____

_____

Gynecology History

Menstruation History:

How old were you when your period first started? age: _____

Date last menstruation started: _____

Usual cycle length (i.e. 28): _____

Is your cycle: Regular / Irregular (Early or Late)

Usual number of bleeding days: _____

Is your flow: Light / Moderate / Heavy

Blood colour: Fresh Red, Scarlet Red, Dark Red, Pink, Purple, Brown, Black

Blood consistency: Watery-thin / Thick / Average

Does your flow have clots? Yes / No

If yes, at what point during the flow: Start / Middle / End

Size of clots: Large / Small / Moderate

Do you experience any menstrual pain? Yes / No

If yes, at what point during the cycle: Before Flow / During / After

If during the cycle, what days? _____

If yes, what type of pain: Cramping / Stabbing / Heavy / Dull / On and off

What relieves the pain? Pressure / Heat / Cold _____

Do you have nipple sensitivity or discharge? Yes / No

Do you have any PMS symptoms?

Bloating, Bowel Movement changes, Cramps, Mood changes, Acne,

Breast tenderness, Headache, Nausea, Fatigue, Sleep disturbances

Any others? _____

Any increase or decrease in energy around menses? Increase / Decrease

If yes, is it: Before / During / After

Any spotting between cycles? Yes / No

If yes, when? Before / Middle / After

Ovulation History:

Any pain mid-cycle? Yes / No

If yes, is it: Right / Left / Bottom Abdomen / Lower Back

Cervical fluid changes mid-cycle: Yes / No

If yes is it: White / Dry / Clear + stretchy

Do you ovulate on your own? Yes / No

Are you more or less energetic around ovulation? More / Less / No change

General History:

Any vaginal secretions (discharge)? Yes / No

If yes, what colour: White / Yellow / Green / Pink / Red

Consistency: Watery / Thick / Sticky

Odour: None / Unpleasant

Date of last physical examination with your General Practitioner (MD): _____

Have you ever had:

○ Abnormal pap smear; details_____

○ Cervical operations; when? _____

○ Yeast infections; last one _____

○ Bladder infections (Urinary Tract Infections)

○ Chlamydia

○ PID (Pelvic Inflammatory Disease)

Have you ever been diagnosed with infections/sexually transmitted disease? Yes / No

If yes, when _____ and how it was treated _____

Have you ever been diagnosed with:

○ Uterine fibroids

○ Endometriosis

○ Polyps

○ PCOS (Polycystic Ovarian Syndrome)

○ Pelvic Adhesions

○ Prolapsed uterus

○ Prolapsed bladder

○ Pelvic abnormalities

○ Other _____

Contraceptive / Sexual History:

Frequency of intercourse: _____ Is intercourse painful?_____

Have you ever taken oral contraceptives? Yes / No

How long? _____ When did you stop? _____ Any problems?_____

Have you had an IUD? Yes / No

How long? _____ When? _____ Any problems? _____

Have you ever taken Depo-Provera? Yes / No

How long, and when? _____

Pregnancy History:

	When (year)	End in abortion	End in miscarriage	Ectopic pregnancy	Infertility therapy	How long to conceive	Current partner the father
1st							
2nd							
3rd							
4th							

Are you pregnant right now? ○ Yes:_____ ○ No

How many weeks? _____

Are you experiencing any problems? _____

Any problems during or after pregnancies in the past? _____

_____

Have you had any D & C's (Dilatation and curettage) performed? _____

How many? _____

Any Additional comments or concerns?_____

_____

_____

_____

Fertility History – fill in if applicable

How long have you been trying to conceive? _____

In this relationship _____ In previous relationship _____

Are you using donor sperm? _____

Is your partner supportive of you trying to conceive? Yes / No

Have you had a Western Medical Diagnosis related to your fertility? Yes / No

What was it? _____

_____

By whom? _____

If you have a male partner, has he had a Western Medical Diagnosis relating to his fertility?

Yes / No

What was it? _____

By whom? _____

Have you ever taken fertility medications? Yes / No

What was it? _____ For how long? _____

Have you had any fallopian tube evaluations or operations? _____

Have you had any hormone laboratory test results? Yes / No

FSH	Normal / High	Progesterone	Normal / High / Low
Prolactin	Normal / High	Testosterone	Normal / High / Low
Thyroid	Normal / High / Low	Other _____	Normal / High / Low

Which of the following tests have you had performed? Check all that apply and the results, if known:

	When:	Results:
○ BBT (Basal Body Temperature)	_____	_____
○ Endometrial Biopsy (Biopsy of the uterine lining)	_____	_____
○ Hysterosalpingogram (X-ray of the uterus and Fallopian tubes with dye)	_____	_____
○ Ultrasound (abdominal and/or endovaginal)	_____	_____
○ Antibodies	_____	_____
○ Laparoscopy, hysteroscopy	_____	_____
○ Mycoplasma / Chlamydia cultures	_____	_____
○ Thyroid tests	_____	_____
○ Other _____	_____	_____

Have you ever had fertility Treatments? (IVF, IUI, etc) Yes / No

What, when and where?_____

How did your body respond to the treatments?

Poor / Average / Adverse reactions _____

Do you use basal body temperature charts, ovulation sticks or saliva ferning tests? Yes / No

Have you been exposed to chemotherapy or radiation? Yes / No

Is your libido? Low / Normal / High

Do you use vaginal Lubricants? Yes / No

Are you more than 20% over or below your ideal body weight? Yes / No

If yes: Over / Under

Do you exercise regularly? Yes / No

How often? _____

Do you have excessively oily skin? Yes / No

Do you have excessive facial or body hair? Yes / No

Have you experienced excessive loss of head hair? Yes / No

Do you have a stressful occupation? Yes / No

Any Additional comments or concerns? _____

CONTEXT OF CARE OVERVIEW:

1. Why did you choose to come to this clinic?

   What do you know about our approach?

2. What are three expectations you have for this visit to our clinic?

   -
   -
   -

   What long term expectations do you have for working with our clinic?

   What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (rate from 0 to 10, 10 being 100% committed)
   1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or lifestyle habits do you currently engage in that you believe support your health? (please list)

   b) What behaviours or lifestyle habits do you currently engage in that you believe have a negative impact on your health? (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are affecting your health or may prevent you from adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

Patient Advisory

During or after an acupuncture treatment certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. No guarantees concerning its use and effects are given and you are free to refuse treatment at any time.

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese herbal substances by a licensed acupuncturist at Double Koi Acupuncture.

Signature_____Date_____

Office Fee Policy

TCM / ACUPUNCTURE

1. Initial Consultation: $70
2. Subsequent Visits: $60

Missed Appointment Fee:

PATIENTS WILL BE CHARGED FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

Payment is due when services rendered and may be paid by cash or cheque.

Having read the statement above I fully understand and accept this fee schedule.

PATIENT'S SIGNATURE: _____ Date: _____