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 _________________

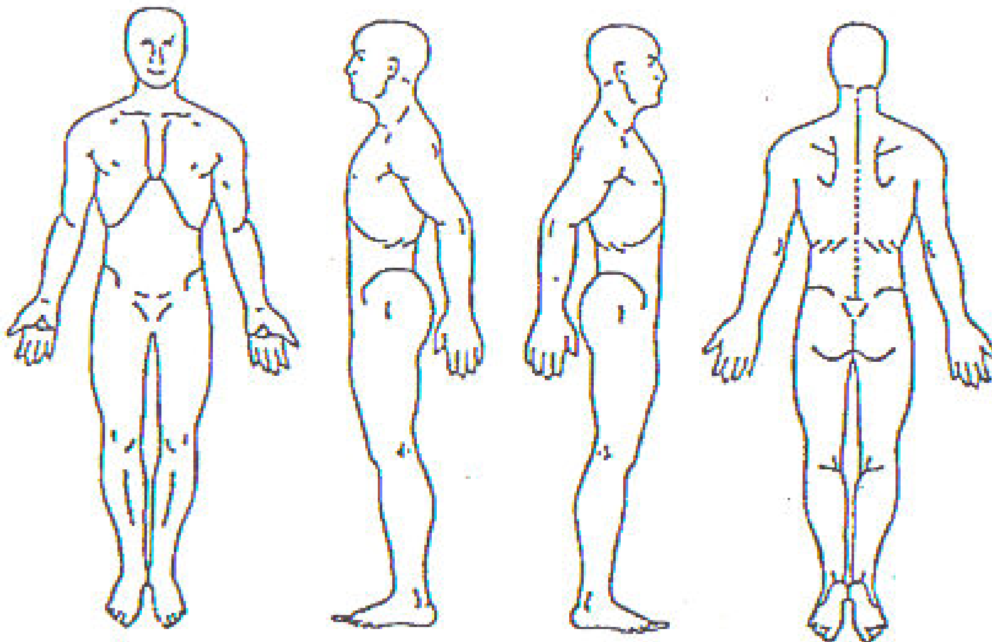
Please inform your TCM practitioner / acupuncturist if any of the following apply to you:

Haemophiliac	○ Yes	○ No
Wear a pacemaker	○ Yes	○ No
Have a serious heart or lung condition	○ Yes	○ No
If you are taking anticoagulant medications?	○ Yes	○ No
Epilepsy	○ Yes	○ No
Are you a vegetarian?	○ Yes	○ No
Do you have surgeries scheduled?	○ 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 <u>three</u> expectations you have for <u>this visit</u> to our clinic?

- ○
- ○
- ○

   What <u>long term</u> 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: __________________