the fertile soul

General Information

Name (First, Middle, Last) _____

Age _____ **Date of Birth** _____ **Sex** _____

Phone _____ **Email** _____

Partner's Name _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Occupation _____

Employed By _____

Employer Address _____

Employer City _____

Employer State _____ **Zip Code** _____ **Business Phone** _____

Social Security Number _____

Emergency Contact and Relationship _____

Emergency Contact Phone _____

I understand that I should seek a physician's evaluation for the condition for which I am requesting consultation. The diagnosis and treatment plan I will be given by The Fertile Soul is based upon Traditional Chinese Medicine principles and natural treatment only and does not constitute a Western medical diagnosis. I understand that I am not to rely on the Traditional Chinese Medical diagnosis and treatment as the sole remedy for the condition for which I am seeking treatment. I understand that if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western medical doctor. Further, if I am concurrently undergoing Western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

Signature _____ **Date** _____

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Fertility History

Age at which menses began _____ **Have your cycles changed since they began?** _____

How?

Do you ovulate on your own? _____ **On what day of your cycle?** _____

Do you experience fertile cervical fluids? _____

Do you experience ovulation pain? _____

Do your breasts get tender at/during ovulation? _____

Do you get premenstrual low back pain? _____

Do your bowel movements become loose at the beginning of your period? _____

Are your periods painful? _____

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? (Light, Normal, or Heavy) _____

What color is the blood? (Light Red, Red, Dark Red, Purple, Brown, or Black) _____

Is there clotting? _____

Do you have premenstrual tension? _____

Does your face break out before or during your period? _____

Do you experience premenstrual headaches? _____

Do your breasts become tender premenstrually? _____

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Do you spot between periods? _____

Are your menstrual cycles spaced irregularly? _____

How many days are there from one period to the next? _____

Date of last menstrual period? _____

Have you had fertility treatments? _____

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medications to help you ovulate? _____

When? _____ **How long?** _____

Have your fallopian tubes been evaluated medically? _____

What are the results? _____

Have you had any tubal operations? _____

Have you had hormone laboratory tests performed? _____

What are the results? _____

Do you have a single partner with whom you have been trying to conceive? _____

How long have you been married or living together? _____

Has he had a fertility workup? _____

What are the results? _____

Is your partner supportive of your wish to conceive? _____

How many pregnancies have you had? **Number** _____ **Years** _____

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How many children do you have? **Number** _____ **Years** _____

How many abortions have you had? **Number** _____ **Years** _____

How many miscarriages have you had? **Number** _____ **Years** _____

How many times has a D&C been performed? **Number** _____ **Years** _____

Have you ever had an abnormal pap smear? _____

Have you ever had a cervical biopsy, operation, cauterization, or conization? _____

Have you ever had a venereal disease? _____

Have you ever been diagnosed with a chlamydial infection? _____

Do you get yeast infections regularly? _____

Do you have chronic vaginal discharge? _____

Do you have any sores on your genitals? _____

Have you ever had pelvic inflammatory disease? _____

Were you treated for it? _____

How?

Date of last pap smear? _____

Have you ever been diagnosed with uterine fibroids or polyps? _____

Have you ever been diagnosed with endometriosis? _____

Have you ever been diagnosed with pelvic adhesions? _____

Have you ever been diagnosed with any pelvic abnormalities? _____

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How heavy is your sexual energy? (Low, Normal, High) _____

Do you douche regularly? _____ **With what?** _____

Do you use vaginal lubricants? _____

Are you more than 20% over your ideal body weight? _____

Do you have a stressful occupation? _____

Do you exercise regularly? _____

Do you have excessive facial hair? _____

Do you have excessively oily skin? _____

Have you experienced excessive loss of head hair? _____

Have you noticed discharge from your nipples? _____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? _____

Have you been exposed to any known environmental toxins or hormones? _____

Are you presently taking steroids? _____

Have you taken oral contraceptives? _____

When? _____ **How long?** _____

Have you ever had an IUD? _____

When? _____ **How long?** _____

Have you taken other forms of hormonal birth control? _____

When? _____ **How long?** _____

How long have you been trying to conceive? _____

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Have you had a diagnosis relating to infertility? _____

What was it? _____

Have you taken any medications for gynecological conditions other than contraceptives? (Please List Below)

1. Medication _____ **How long?** _____

Reason?

2. Medication _____ **How long?** _____

Reason?

3. Medication _____ **How long?** _____

Reason?

4. Medication _____ **How long?** _____

Reason?

5. Medication _____ **How long?** _____

Reason?

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Medical History

Major Health Complaint/Problem?

How did this condition develop?

How long has this condition persisted? _____

Is there anything that makes it better? _____

Is there anything that makes it worse? _____

Have you ever received treatment for this condition? _____

If yes, when and where? _____

By whom? _____

What was the diagnosis? _____

What kind of treatment did you receive? _____

What were the results of the treatment? _____

List any substances you are allergic to: _____

List any medications you are currently taking (other than the medications listed in the Fertility History form):

1. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

2. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

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3. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

4. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

5. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

6. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

7. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

List any major surgeries you have had:

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Significant Trauma (Auto accidents, falls, etc.?)

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Significant illnesses:

_____ Arthritis
_____ Asthma
_____ Autoimmune Disease
_____ AIDS
_____ Cancer
_____ Connective Tissue Disease
_____ Diabetes
_____ Gallstones
_____ Heart Disease
_____ Hepatitis
_____ Hypertension
_____ Kidney Stones
_____ Rheumatic Fever
_____ Ruptured Appendix
_____ Seizures
_____ Thyroid Disease
_____ Venereal Disease

Health History

Please indicate any symptoms you have or have had in the past year.

General

_____ Chills
_____ Low energy
_____ Dizziness
_____ Allergies
_____ Fatigue
_____ Fevers
_____ Excess thirst
_____ Insomnia
_____ Nervousness
_____ Numbness
_____ Sweat spontaneously
_____ Night sweating
_____ Lack of sweating
_____ Weight loss
_____ Weight gain
_____ Aversion to heat
_____ Aversion to cold

Head & Neck

_____ Blurred vision
_____ Heaviness in the head
_____ Headache
_____ Phlegm in throat

Head and Neck cont'd

_____ Cataract
_____ Double vision
_____ Earache
_____ Ear discharge
_____ Eye pain/strain
_____ Corrected vision
_____ Nasal obstruction
_____ Nasal discharge
_____ Loss of sense of smell
_____ Hearing loss
_____ Hoarseness
_____ Nosebleeds
_____ Recurrent sore throat
_____ Red/inflamed eye
_____ Ringing in ears
_____ Sinus problems
_____ Sore on lips
_____ Sores on tongue
_____ Taste change
_____ Teeth problems
_____ Vision - see halos

Respiratory

_____ Asthma
_____ Hay fever
_____ Persistent cough
_____ Coughing blood
_____ Shortness of breath
_____ Recurrent bronchitis
_____ Phlegm production
_____ Difficulty inhaling
_____ Difficulty exhaling

Cardiovascular

_____ Chest pain
_____ High blood pressure
_____ Low blood pressure
_____ Irregular heart beat
_____ Poor circulation
_____ Swelling of ankles
_____ Varicose veins
_____ Hypochondriac pain
_____ Distention in chest or hypochondrium

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Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

Diet & Lifestyle

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly

Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning on urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Musculosketal Pain

Weakness or numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin

Skin cont'd

- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry brittle hair
- Hair falling out

Neurological

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

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Women Only

- [ ] Abnormal pap smear
- [ ] Bleed between periods
- [ ] Irregular periods
- [ ] Heavy periods
- [ ] <25 day cycle (less)
- [ ] >25 day cycle (greater)
- [ ] Endometriosis
- [ ] Painful periods
- [ ] Premenstrual tension
- [ ] Breast lumps
- [ ] Contraceptives
- [ ] Sore on genitalia
- [ ] Low sexual energy
- [ ] Vaginal discharges
- [ ] Menopausal
- [ ] Uterine prolapse
- [ ] Facial Hair
- [ ] Loss of body hair
- [ ] May be pregnant