

**Welcome to Lavender Retreat Wellness Club**

1236 Pennsylvania Ave SE, Washington DC, 20003

Acupuncture

 New Patient Intake Form

intake

All written records are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client’s legal guardian — unless legally required by local, state or federal subpoena, summons, or other court order.

**“All Patients have to eat a small snack an hour before the treatment”**

Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_ lbs

Sex: □ Male □ Female

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Married □ Single □ Divorced □ Widowed

□ Partnered Number of Children:

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the main health problems for which you are seeking treatment:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity of Symptoms 1-10 (1 mind/ 10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity of Symptoms 1-10 (1 mind/ 10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity of Symptoms 1-10 (1 mind/ 10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other forms of treatment have you sought?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What are your goals of treatment?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all past Hospitalizations, Surgeries or Accidents (car accident, fall etc, include Date):** (if extensive, provide list)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies, Food Sensitivities:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescription drugs you are currently taking:** (if more than 4 provide list)

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins, Supplements, Over-the-Counter Medication you are currently taking:** (if more than 4 provide list)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check the Box if any of the following statements is true:**

□ I have known allergies □ I am taking Coumadin/Warfarin □ History of Seizures or Seizure like activity □ I have a pacemaker □ I am taking Lithium □ History of Head Trauma

FAMILY MEDICAL HISTORY

(Check the following conditions that have occurred in your blood relatives-grandparents, parents or siblings)

□ Allergies (list) □ Alcoholism □ Depression □ High Blood Pressure □ Tuberculosis □ Arteriosclerosis □ Cancer (type) □ Diabetes □ Seizures □ Obesity □ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Heart Diseases □ Stroke

**YOUR PAST MEDICAL HISTORY**

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

□ AIDS/HIV □ Cancer: \_\_\_\_\_\_\_\_\_\_\_\_ □ Measles □ Seizures □ Herpes (Type: \_\_\_\_\_\_\_) □ Alcoholism □ Chicken Pox □ Multiple Sclerosis □ Stroke □ High Blood Pressure □ Allergies

□ Diabetes (Type: \_\_\_\_\_) □ Mumps □ Thyroid Disorders □ Venereal disease □ Appendicitis □ Emphysema □ Pacemaker □ Tuberculosis □ Rheumatic Fever □ Arteriosclerosis □ Gout □ Pleurisy

□ Typhoid Fever □ Scarlet Fever □ Asthma □ Heart Disease □ Pneumonia □ Ulcers □ Epilepsy □ Birth Trauma □ Hepatitis (Type: \_\_\_\_\_) □ Psychological Disorder □ Whooping Cough □ Goiter

Other significant Past Medical problems/medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL LIFESTYLE HABITS**

Cigarettes (packs) \_\_\_\_\_\_\_\_\_\_\_\_ Coffee/Tea (cups per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol (drinks per week) \_\_\_\_\_\_\_\_\_\_\_ Recreational drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Water intake (cups/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dairy Diet that you might eat on a typical day?

• Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What non-work activities do you Enjoy doing?** (reading, hiking, TV, meditation, music, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Life Stresses: \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP BEHAVIOR**

What time do you go to bed at night: \_\_\_\_\_\_\_\_\_\_\_What time do you wake in the morning: \_\_\_\_\_\_\_\_\_\_

Do you fall asleep easily? □ Yes □ No if no, how long does it take you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you stay asleep throughout the night? □ Yes □ No if no, how often do you wake throughout the night?

Do you wake rested? □ Yes □ No / Do you have vivid dreaming? □ Yes □ No / Sweat at night? □ Yes □ No

Do you wake to urinate in the middle of the night? □ Yes □ No

if yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVERALL TEMPERATURE**

(Check all the following that apply to you.)

□ Cold Hands □ Sweaty Hands □ Usually feel Hot □ Sweat Easily □ Hot flashes any time

□ Cold Feet □ Sweaty Feet □ Usually feel Cold □ Afternoon Flushes □ Heat/Warmth in Face

**MEDICAL REVIEW OF SYSTEMS**

Please Fill this out Carefully. **One Check** = Symptom you have experienced **Two Checks** = Frequently occurring symptom

**GENERAL SYMPTOMS**

□ Poor appetite □ Large appetite □ Being overweight □ Strongly like cold drinks □ Strongly like hot drinks □ Recent weight Loss/Gain □ Fatigue □ Excessive sleeping □ Difficulty sleeping □ Lack of strength □ Bodily heaviness □ Easily catch colds □ Vague Flu-like symptoms □ Excessively thirsty □ Poor circulation □ Shortness of breath □ Fever □ Chills □ Vertigo or dizziness □ Bleed or bruise easily □ Peculiar taste in mouth □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPIRATORY**

□ Difficulty breathing when lying down □ Shortness of breath □ Tight chest □ Asthma/wheezing

□ Difficult inhalation? exhalation? □ Cough Wet or Dry? \_\_\_\_\_\_\_\_\_\_\_ Thick or Thin? \_\_\_\_\_\_\_\_\_ Color of phlegm \_\_\_\_\_\_\_\_ □ Coughing up blood □ Pneumonia

**CARDIOVASCULAR**

□ High blood pressure □ Blood clots □ Low blood pressure □ Fainting □ Chest pain □ Difficulty breathing □ Tachycardia □ Heart palpitations □ Irregular heartbeat □ Ankle swelling/edema

**PSYCHOLOGICAL**

□ Depression □ Anxiety □ Irritability □ Easily stressed □ Tendency to become Obsessive

□ Seeing a therapist

**GASTROINTESTINAL**

□ Nausea □ Vomiting □ Acid reflux □ Gassy □ Abdominal bloating □ Abdominal pain □ Bad breath □ Diarrhea □ Constipation □ Black stools □ Blood in stools □ Mucous in stools □ Hemorrhoids

□ Itchy or burning anus □ Intestinal pain or cramping □ Rectal pain □ Colitis/Diverticulitis □ Laxative use

What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Daily Bowel Movements \_\_\_\_\_\_\_

**MUSCULOSKELETAL**

□ Neck/Shoulder pain □ Muscle cramps or pain □ Upper back pain □ Low back pain □ Joint pain or stiffness □ Rib side pain □ Leg pain □ Radiating pain

**GENITOURINARY**

□ Pain on urination □ Frequent urination □ Urgent urination □ Blood in urine □ Unable to hold urine

□ Incomplete urination □ Wake to urinate □ Bed wetting □ Excessive Libido □ Low Libido □ Kidney Stone

□ Impotence □ Premature Ejaculation □ Nocturnal emission □ Pain with Intercourse

**MALES**

□ Inability to ejaculate or orgasm □ Scrotal pain □ Abnormal penis discharge □ Retention of urine

□ Post Void dribbling □ BPH, Prostatitis Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD, EYES, EARS, NOSE & THROAT**

□ Headaches □ Migraines □ Head injury □ Neck pain or stiffness □ Facial pain □ Glasses (What age: \_\_\_\_\_\_\_)

□ Eye strain □ Eye pain □ Red eyes □ Itchy eyes □ Eyes Sensitive to light □ Poor vision □ Blurred vision

□ See spots/shadows □ Double vision □ Glaucoma □ Cataracts □ Teeth problems □ Grinding teeth

□ TMJ □ Gum problems □ Sores on lips or tongue □ Dry mouth □ Excessive Saliva□ Excessive phlegm Color: \_\_\_\_\_\_\_\_\_\_\_ □ Sinus problems □ Recurrent sore throat □ Lumps in throat □ Enlarged Thyroid

□ Nosebleeds □ Ringing in ears (High or Low?) □ Poor hearing □ Earaches

**NEUROLOGICAL**

□ Dizziness □ Drowsiness □ Muscle spasms or tremors □ Poor memory □ “Tics” □ Numbness

□ Convulsions/Seizures □ Slurred speech □ Speech problems (other) □ Weakness in muscles

**SKIN, HAIR**

□ Dry hair or Skin □ Itchy skin or Scalp □ Hair loss □ Eczema or Psoriasis □ Recurrent fungal infections □ Changing moles □ Increased perspiration

**GYNECOLOGY**

Are you currently pregnant? □ Yes □ No

Age of first menses: \_\_\_\_\_\_\_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of flow \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood clots: □ Yes □ No if yes, what color are they? \_\_\_\_\_\_\_\_\_\_\_\_ Length of cycle (i.e. 28 days) \_\_\_\_\_\_\_\_\_\_

Color of Menstrual blood: □ Pale Red □ Bright Red □ Red □ Dark Red □ Brown

Texture of menstrual blood: □ Thick □ Thin □ Watery □ Normal

Amount of menstrual blood: □ Light flow □ Heavy flow □ Spotting □ Normal

Pain: □ Yes □ No if yes when? (before, during or after menses) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Pain: □ Sharp □ Cramping □ Bloating □ Burning □ Bearing down sensation

Irregular periods(describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMS (irritability, breast tenderness etc, please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current method of contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past method of contraception: \_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any premature births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary tract infections: □ Yes □ No How frequent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal discharge (describe color): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap smear: □ Normal / □ Abnormal \_\_\_\_\_

Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts

□ PID □ Interstitial Cystitis □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Symptoms related to Menses:

□ Swollen Breasts □ Nausea □ Poor appetite □ Vaginal dryness □ Headache □ Diarrhea □ Constipation

□ Mood Swings □ Ravenous appetite □ Hot flashes □ Night sweats □ Increased libido □ Decreased libido □ Insomnia

Menopause (date of onset): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bleeding since Menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? □ Yes □ No if yes, Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any side effects? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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