**Chinese Medicine Therapy & Fertility Center**

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510-353-3309

**Patient Intake Form**

Full Name:

Gender:

DOB:

Email:

Phone Number:

Home Address:

Emergency Contact Information

Name:

Phone:

Relation to you:

Height:

Body weight:

Body temperature:

Blood pressure:

Heart rate:

General Health

Have you ever suffered from an illness that required hospitalization or long term medication? (If Yes, please describe)

Today’s date:

Main complaint:

Fertility history:

How long have you been trying to get pregnant?

What’s the sex life pattern?

Have you been tracking ovulation?

* Home ovulation (LH) kit
* Basal body temperature
* Phone app
* Other

Have you ever been pregnant before? When? What’s the outcome?

Have you ever had abortions/miscarriages? If yes, be more specific.

Have you ever had fertility treatment in the past? If yes, be more specific.

Past contraception use: check and indicate how long you’ve used it:

* Birth control pill/patch/ring
* IUD
* Condoms

Menstrual/Gynecological history:

Age of Menarche (when you had your first period):

First day of your last 3 periods:

How long is the bleeding period?

How is the amount of blood?

What’s the color of the blood?

Are there any clots?

Do you have cramps?

Are the breasts swollen or tender during menstruation?

What’s the PMS symptoms if you have any?

List all Western diagnosis:

List all treatments history:

List all medication, and how long you have been taking them:

General body condition:

1

How is your overall energy, from 1-10, 1 being the lowest?

Do you need to take naps during the day? How many times usually?

2.

Do you have chill or aversion to cold/wind?

Are your hands and feet cold?

Do you have headaches/migraines? If yes, be more specific.

Does the neck feel stiff and uncomfortable?

Do you sweat? If yes, do you sweat during day time, or at night time?

Do you have low back pain?

Do you have any skin issues/itchiness?

3.

Do you have aversion to heat?

How is your appetite?

Do you get full quickly even just eat a little bit?

Do you feel bloated after eating?

Do you prefer warm food or cold food?

Is it uncomfortable to eat cold stuff?

Are you allergic to any food? Nuts, eggs, milk etc..

Do you have acid reflex?

Do you feel chest tightness and/or shortness of breath?

Do you burp, belch, or pass gas? If yes, be more specific.

Do you feel nauseous? Do you vomit? If yes, describe the vomitus.

Describe your bowel movement, frequency, form, odor, consistency?

Do you have belly gurgles?

4.

How is your sleep? Describe it

Do you feel dizzy?

Do you experience heart palpitation?

How is your mood? Are you stressed/depressed/irritable?

Do you have any issues with orifices? Such as itchy or watery eyes, nose bleeding, mouth ulcer, tinnitus, hemorrhoid. etc

Do you have bitter taste in your mouth?

Do you have pain, tenderness, soreness, at sides of body trunk, under the rib cage?

Do you have burning pain or any other weird sensation on your throat?

Do you have burning pain or any other weird sensation along esophagus (the center of your chest)?

Do you have teeth/gum bleeding when brush your teeth?

5.

Do you have a dry mouth?

Do you feel thirsty in general?

Do you want to drink water often when you feel thirsty? What temperature water you prefer?

How is your urine? Frequency, flow, color, how many night urine?

Do you have swelling in any part of your body?

6.

Do you feel becoming forgetful?

Do you have any pain in your body? If yes, be more specific.

7.

Are there any other conditions we haven’t mentioned above that you would like the doctor to know?