triangle ACUPUNCTURE clinic, LLC

104 S. Estes Dr
Suite 104
Chapel Hill, NC
27514

2601 Lake Dr.
Suite 103
Raleigh, NC
27607

Welcome to Triangle Acupuncture Clinic. To help us provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have questions please ask us. Thank you for your time.

CONTACT INFORMATION

Name: Today's Date:

Street Address: City, State: Zip:

Primary Phone: ( ) Please indicate: home work cell (circle one)

Secondary Phone: ( ) Please indicate: home work cell (circle one)

Circle the Best Number to Reach You: primary secondary

Email Address:

In Case of Emergency, Contact: Phone: ( ) circle: h w c

How did you hear about us?

We like to thank those that refer to us. Name of person who referred you:

Marital/Relationship Status: Occupation:

Birth Date + Age: Height: Weight: Sex:

Primary Physician's Name: Date of last visit:

OB/GYN's Name: Date of last visit:

Reproductive Endocrinologist's Name: Date of last visit:

Other Health Care Providers You See Regularly and For What Conditions:

FERTILITY HISTORY

Age period began: How many days do you normally bleed?

How heavy is the bleeding? Light Medium Heavy

What color is the blood? Light Red Red Dark Red Purple Brown Black

What is the consistency of the blood? Watery Thick Clots Dry Phlegmy

Do you suffer from painful periods? When and how many days do you have pain?

Check yes or no	**Yes**	**No**
Premenstrual Moodiness		
Premenstrual Low Back Pain		
Premenstural Acne or Breakouts		
Premenstural Breast Tenderness		
Loose Bowels Premenstrually or During Period		
Premenstrual Water Retention or Bloating		
Bleed or Spot Between Periods		
Do you douche?		
Do you use vaginal lubricants during sex?		

please continue to next page

Does your menstrual cycle follow a regular pattern?

How many days from the start of one period to the start of another?

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

Have your cycles changed since they began or at anypoint in time recently? How?

Date of last menstrual period: Number of pregnancies:

Number of children and ages: Number of abortions:

Number of miscarriages: Number of times a D & C has been performed:

Please circle and indicate the date if you have had any of the following:

abnormal PAP smear	chronic vaginal discharge
venereal disease	pelvic inflammatory disease
chlamydia	uterine fibroids or polyps
yeast infection	genital sores
endometriosis	pelvic abnormalities
pelvic adhesions	cervical biopsy/operation
hemorrhage	other:

Please list any medications you have taken for any other gynecological conditions:

Have you ever taken oral contraceptives? When and for how long?

Have you ever had an IUD or taken DepoProvera? When and for how long?

How long have you been trying to conceive?

Cause of Infertility (doctor's diagnosis):

Are your fallopian tubes open? Have you had abdominal surgery?

What is your day 3 FSH? AMH? Prolactin level?

Have your estrogen or progesterone levels been found to be low?

Have you had your thyroid tested? Antibodies?

Describe in chronological order all other fertility treatments (injectables, IUI, IVF, FET):

Date (month/year):

Date:

Date:

Date:

Date:

Date:

Date:

Date:

please continue to next page

Is your partner supportive of your wish to conceive?

Male partners: Has he had a fertility workup? Results?

How is your sexual energy? Low Normal High

How is your relationship with your partner now? Not Good Stressed Good Awesome

Do you have a support system of friends and family?

Describe your stress level and any predominant emotions you are experiencing:

What do you currently do to promote relaxation and combat stress?

Any other thoughts or information related to your physical or emotional health that you would like to share?

CURRENT HEALTH

How many glasses of water do you drink per day?

What other beverages do you consume daily?

Briefly describe your diet and any special diets: (use the back if needed)

Do you smoke/chew tobacco? How much and how often?

Do you consume caffeine? How much and how often?

Do you consume alcohol? How much and how often?

Do you use recreational drugs? How much and how often?

Please list all vitamins and supplements you are taking:

please continue to next page

Please list all prescription and over-the-counter medications you are taking, dosages for each and why you are taking each: (use the back of form if more room is needed):

List any drug allergies:

PAST AND FAMILY MEDICAL HISTORY

Please list any major illnesses and operations, and the date of onset of each:

Date of last PAP: Date of last mammogram:

Please check all that apply:

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Anemia							
Cancer							
Diabetes							
High Blood Pressure							
Stroke							
Heart Disease							
Depression							
Mental Illness							
Hepatitis							
HIV/AIDS							
Autoimmune Disease							
Infectious Disease							
MRSA/Staff Infection							
Other							
Age at Death							

Please continue to the following forms:

HIPAA

Office Policy

*Arbitration/Informed Consent (front and back) *this form is completed in the office*