Angea
Acupuncture
& Yoga

Angea Fertility Clinic
3/17 Izett Street, Prahran, Victoria 3181
Phone: 03 9510 3700
Email: info@angea.com.au

Women's Fertility Forms

Date:

Last name /	First name /	Tick: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

Birth date /	Age /	Preferred # (please tick)
Address /		Phone (home) /
City /		Phone (work) /
Country /	Post Code /	Phone (mobile) /
Email /		Occupation

Reason for Visit /

Have you had Acupuncture before? ☐ Yes ☐ No

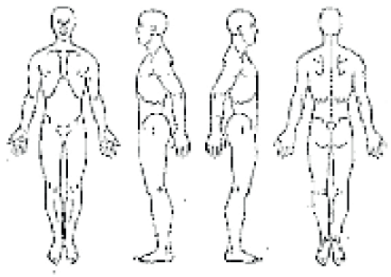
Chinese herbal medicine? ☐ Yes ☐ No

Family Physician name /	Family Physician Phone /
Western Medical diagnosis (if applicable) /	
Other medical treatment received (tick) / ☐ Fertility clinic ☐ Physiotherapy ☐ Massage ☐ Naturopathy ☐ Chiropractic ☐ Other:	

Please indicate with a **P** (past) **C** (current) **F** (family) if any conditions below apply:

	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV/AIDS		Sprain/Strain/Fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Hemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain ;



Sensations/pain characteristics (check):
Sharp __ Burning __ Moving __ Tingling __ Dull __ Severe __
Stabbing __ Shooting __ Throbbing __ Numbness __

What relieves the pain (ice, rest, activity, massage, heat...)?

What aggravates the pain (weather, heat, cold, rest, actibity...)?

Please list any prescription medication or over the counter drugs currently taking:

1.2
3.4
5.6

Please list herbal medicine and other supplements currently taking:

1.2
3.4
5.6

Please list any allergies (food, drugs, environmental etc.):

Have you been hospitalised and/or treated for any infectious/ serious conditions or surgeries? If yes, briefly explain for what condition or reason and the year (below):

Do you use the following? If so, how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Soft Drinks: _____

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Angea Fertility Clinic? (Internet, Friend, Doctor, Fertility Clinic, Seminar, Magazine, TV, news)

For each symptom below that you currently have, rate its severity from 1 5 (5 being worst). Leave blank if N / A.

Gan

____ Irritability / frustration / impatient
____ Depression
____ Stress
____ Emotional eating
____ Unfulfilled desires
____ Visual problems / floaters
____ Blurred vision / poor night vision
____ Red / Dry / Itchy eyes
____ Headaches / Migraines
____ Dizziness
____ Feeling of lump in throat
____ Muscle twitching / spasm
____ Neck / shoulder tension
____ Brittle nails
____ Sighing
____ Sensation or pain under rib cage
____ PMS
____ Genital itching / pain / rashes

Shen

____ Frequent urination
____ Bladder infection
____ Lack of Bladder control
____ Wake to urinate
____ Feel cold easily
____ Cold hands / feet
____ Night sweats / hot flushing
____ Low sex drive
____ High sex drive
____ Loss of head hair
____ Hearing problems
____ Crave salty food
____ Fear
____ Poor long term memory
____ Ankle swelling
____ Tinnitus

Pi

____ Heaviness in the head / body
____ Fatigue / after eating
____ Difficult getting up in morning
____ Water retention
____ Muscular tired / weak
____ Bruise easily
____ Unusual bleeding (stool, nose, etc)
____ Bad breath
____ Poor appetite
____ Increased appetite
____ Crave sweets
____ Poor digestion
____ Nausea / vomiting
____ Bloating / gas
____ Hemorrhoids
____ Constipation
____ Loose stool
____ Alternate constipation / loose
____ Abdominal pain
____ Intestinal pain / cramping
____ Heartburn
____ Pensive / over-thinking
____ Overweight
____ Foggy mind
____ Yeast infection
____ Aversion to cold
____ Cold nose
____ Increased Thirst
____ Prefer Warm / Cold drinks
____ Sweat easily

Xin

____ Palpitations
____ Chest pain / tightness
____ Insomnia / Sleep problems
____ Restless / easily agitated
____ Vivid dreams
____ Lack of joy in life
____ Forgetful
____ Aversion to heat
____ Bitter taste in mouth
____ Tongue / mouth ulcers / cankers

Fei

____ Dry cough
____ Cough with Phlegm
____ Nasal discharge / drip
____ Sinus infection / congestion
____ Itchy / painful throat
____ Dry mouth / throat / nose
____ Skin rashes / hives
____ Snoring
____ Grief / sadness
____ Shortness of breath
____ Allergies / asthma
____ Weak immune system
____ Alternate fever / chills

Besides fertility, list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How Many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

Date last menses began / Is your menstrual cycle: Regular ☐ Irregular ☐

How old were you when you had your first menstruation?	How many days do you bleed in total /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ☐ Light ☐ Average ☐ Consistency of blood: Watery ☐ Thick ☐ Average ☐

Does your blood contain clots? Yes ☐ No ☐ …and... At which point during the cycle? Start ☐ Mid ☐ End ☐

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ☐ No ☐	Before menses During (please specify which days) After
What relieves the pain?	Stabbing ☐ Cramping ☐ Dull ☐ Heavy ☐ On/off ☐

Do you experience Pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness ☐ Cramps ☐ Acne ☐ Change in Bowel ☐ Bloating ☐ Headaches ☐ Nausea ☐ Moodiness ☐

Fatigue ☐ Night sweats ☐ Sleep disturbances ☐

Please list any other pre-menstrual symptoms:

Do you ovulate on your own? Yes ☐ No ☐ What Day?	Do you chart your cycle? (tick) BBT ☐ Ovulation sticks ☐ Saliva ☐
Do you experience pain around ovulation? Yes ☐ No ☐	Do your breasts get tender around ovulation? Yes ☐ No ☐
Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes ☐ No ☐	

How many times have you been pregnant? How many times have you given birth?

Ages of children Sex of Children Given names

Have you had any miscarriages? Yes ☐ No ☐

If yes, how many, at how many weeks pregnant, and in what year(s)?

How many times have you had a D&C preformed?

How many abortions have you had? In what year(s)?

Were there any problems that occurred during these pregnancies?

Have you ever been diagnosed with:	Date of last pap smear: (dd/mm/yyyy)
STD? ..... Yes ☐ No ☐	Have you ever had an abnormal pap smear? Yes ☐ No ☐
Pelvic inflammatory disease? ..... Yes ☐ No ☐	Have you ever had a cervical biopsy or operation? Yes ☐ No ☐
Uterine fibroids? ..... Yes ☐ No ☐	Do you get yeast infections regularly? Yes ☐ No ☐
Polyps? ..... Yes ☐ No ☐	Do you get bladder infections regularly? Yes ☐ No ☐
Pelvic adhesions? ..... Yes ☐ No ☐	If answered yes, list STD's:
Prolapsed uterus? ..... Yes ☐ No ☐	
Unique shape of uterus? ..... Yes ☐ No ☐	
Endometriosis? ..... Yes ☐ No ☐	
PCOS (polycystic ovarian syndrome)? ..... Yes ☐ No ☐	

Do you experience vaginal discharge? Yes ☐ No ☐

If yes, what colour?

White ☐ Yellow ☐ Green ☐ Pinkish ☐ Red ☐

If yes, what consistency?

Watery / thin ☐ Thick ☐ Sticky ☐

If yes, does it have foul odour? Yes ☐ No ☐

Have you taken oral contraceptives? Yes ☐ No ☐

If yes, for how long?

When did you stop?

Have you ever had an IUD? Yes ☐ No ☐

Have you ever taken Depo-Provera? Yes ☐ No ☐

Do you have a single partner with whom you have been trying to conceive? Yes ☐ No ☐
How long have you been married or living together? What is your partner's name?
How long have you been trying to conceive? Are they supportive of your wishes to conceive? Yes ☐ No ☐

Have either you or your partner had a western medical diagnosis relating to fertility? Yes ☐ No ☐
What was the diagnosis?
Who made the diagnosis?

Have you had any hormone lab tests performed? (i.e. day 3 / 21)			
FSH …….	☐ Normal	☐ High	☐ Low
Estrogen, E2…….	☐ Normal	☐ High	☐ Low
Progesterone…….	☐ Normal	☐ High	☐ Low
Prolactin …….....	☐ Normal	☐ High	☐ Low
Thyroid ……..	☐ Normal	☐ High	☐ Low
Testosterone ……	☐ Normal	☐ High	☐ Low
Other:			

Have you taken medication to help you ovulate?
Yes ☐ No ☐
If yes, what kind?
For how many cycles?
Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes ☐ No ☐
What were the results?

Have you had any tubal operations? Yes ☐ No ☐

Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF, ICSI, superovulation, etc) Yes ☐ No ☐

Month / Year	Type of treatment	Clinic	Results

How did you respond to the fertility treatments? Poor ☐ Good / average ☐

Are you using donor sperm? Yes ☐ No ☐ If Yes, why? (tick) female partner ☐ male partner has semen issues ☐

How is you sexual desire (mental interest) ? Low ☐ Normal ☐ High ☐

How is your sexual arousal (physically / orgasm) ? Low ☐ Normal ☐ High ☐

Do you use vaginal lubricants? Yes ☐ No ☐

Have you been exposed or received chemotherapy or radiation? Yes ☐ No ☐

Do you have excessive facial / body hair? Yes ☐ No ☐

Do you have excessive oily skin? Yes ☐ No ☐

What is your weight? How tall are you?

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to Angea Fertility is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Angea, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Angea (also, Angea will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy
format on Angea premises. On occasion, Angea may use client/patient information to conduct clinical studies to help us improve upon services provided.

Full Name (Print name of representative if represented by another)

Signature (Signature of Representative)

Date

Appointment Policy

Welcome to Anjea Fertility Clinic. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of $80. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.

Full Name Date

Signature