

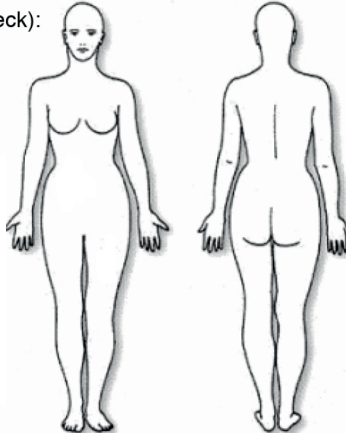
Women's General Gynecology Forms

Date:

Last name /		First name /		Tick: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
Birth date /		Age /		Phone (home) /	
Address /				Phone (work) /	
City /				Phone (mobile) /	
Country /		Post Code /		Occupation /	
Email /				Height /	
				Weight /	
Reason for Visit /				Have you had Acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Physician name /			Family Physician Phone /		
Western Medical diagnosis (if applicable) /					
Other medical treatment received (tick) / <input type="checkbox"/> Fertility clinic <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Massage <input type="checkbox"/> Naturopathy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Other:					

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

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

<p>On the figures below, please circle the areas of concern/pain;</p> <p>Sensations/pain characteristics (check): Sharp ___ Burning ___ Moving ___ Tingling ___ Dull ___ Severe ___ Stabbing ___ Shooting ___ Throbbing ___ Numbness ___</p> <div style="text-align: center;">  </div> <p>What relieves the pain (ice, rest, activity, massage, heat...)?</p> <p>What aggravates the pain (weather, heat, cold, rest, activity...)?</p>	<p style="background-color: #fce4d6;">Please list any prescription medication or over the counter drugs currently taking:</p> <p>1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____</p> <p style="background-color: #fce4d6;">Please list herbal medicine and other supplements currently taking:</p> <p>1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____</p> <p style="background-color: #fce4d6;">Please list any allergies (food, drugs, environmental etc.):</p> <p>_____</p> <p style="background-color: #fce4d6;">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):</p> <p>_____</p>
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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		Shen		Pi	
<input type="checkbox"/>	Irritability / frustration / impatient	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Heaviness in the head / body
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	Fatigue / after eating
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Lack of Bladder control	<input type="checkbox"/>	Difficult getting up in morning
<input type="checkbox"/>	Emotional eating	<input type="checkbox"/>	Wake to urinate	<input type="checkbox"/>	Water retention
<input type="checkbox"/>	Unfulfilled desires	<input type="checkbox"/>	Feel cold easily	<input type="checkbox"/>	Muscular tired / weak
<input type="checkbox"/>	Visual problems / floaters	<input type="checkbox"/>	Cold hands / feet	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	Blurred vision / poor night vision	<input type="checkbox"/>	Night sweats / hot flushing	<input type="checkbox"/>	Unusual bleeding (stool, nose, etc)
<input type="checkbox"/>	Red / Dry / Itchy eyes	<input type="checkbox"/>	Low sex drive	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	Headaches / Migraines	<input type="checkbox"/>	High sex drive	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loss of head hair	<input type="checkbox"/>	Increased appetite
<input type="checkbox"/>	Feeling of lump in throat	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	Crave sweets
<input type="checkbox"/>	Muscle twitching / spasm	<input type="checkbox"/>	Crave salty food	<input type="checkbox"/>	Poor digestion
<input type="checkbox"/>	Neck / shoulder tension	<input type="checkbox"/>	Fear	<input type="checkbox"/>	Nausea / vomiting
<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	Poor long term memory	<input type="checkbox"/>	Bloating / gas
<input type="checkbox"/>	Sighing	<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Sensation or pain under rib cage	<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	PMS			<input type="checkbox"/>	Loose stool
<input type="checkbox"/>	Genital itching / pain / rashes			<input type="checkbox"/>	Alternate constipation / loose
Xin		Fei		<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Dry cough	<input type="checkbox"/>	Intestinal pain / cramping
<input type="checkbox"/>	Chest pain / tightness	<input type="checkbox"/>	Cough with Phlegm	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Insomnia / Sleep problems	<input type="checkbox"/>	Nasal discharge / drip	<input type="checkbox"/>	Pensive / over-thinking
<input type="checkbox"/>	Restless / easily agitated	<input type="checkbox"/>	Sinus infection / congestion	<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Vivid dreams	<input type="checkbox"/>	Itchy / painful throat	<input type="checkbox"/>	Foggy mind
<input type="checkbox"/>	Lack of joy in life	<input type="checkbox"/>	Dry mouth / throat / nose	<input type="checkbox"/>	Yeast infection
<input type="checkbox"/>	Forgetful	<input type="checkbox"/>	Skin rashes / hives	<input type="checkbox"/>	Aversion to cold
<input type="checkbox"/>	Aversion to heat	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	Cold nose
<input type="checkbox"/>	Bitter taste in mouth	<input type="checkbox"/>	Grief / sadness	<input type="checkbox"/>	Increased Thirst
<input type="checkbox"/>	Tongue / mouth ulcers / cankers	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Prefer Warm / Cold drinks
		<input type="checkbox"/>	Allergies / asthma	<input type="checkbox"/>	Sweat easily
		<input type="checkbox"/>	Weak immune system		
		<input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	Before menses	During	(please specify which days) After
What relieves the pain?	Stabbing <input type="checkbox"/>	Cramping <input type="checkbox"/>	Dull <input type="checkbox"/> Heavy <input type="checkbox"/> On/off <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/> What Day?	Do you chart your cycle? (tick) BBT <input type="checkbox"/> Ovulation sticks <input type="checkbox"/> Saliva <input type="checkbox"/>
Do you experience pain around ovulation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do your breasts get tender around ovulation? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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 <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had an abnormal pap smear? Yes <input type="checkbox"/> No <input type="checkbox"/>
Pelvic inflammatory disease? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had a cervical biopsy or operation? Yes <input type="checkbox"/> No <input type="checkbox"/>
Uterine fibroids? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you get yeast infections regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>
Polyps? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you get bladder infections regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>
Pelvic adhesions? Yes <input type="checkbox"/> No <input type="checkbox"/>	If answered yes, list STD's:
Prolapsed uterus? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Unique shape of uterus? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Endometriosis? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PCOS (polycystic ovarian syndrome)? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

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