

# The Center For Reproductive Healing

## Patient Information

CONFIDENTIAL

The Center for Reproductive Healing □ 44 W. Market Street □ Marietta, PA 17547  
www.ReproductiveHealing.com

Phone: 1-877-619-2006

### Welcome to The Center for Reproductive Healing

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Center for Reproductive Healing considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP

OCCUPATION
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EMPLOYED BY		
EMPLOYERS ADDRESS		
CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER
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SPOUSE'S NAME
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CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE
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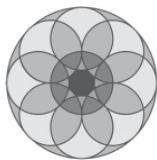
ADDITIONAL INFORMATION / NOTES
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I understand that I should be evaluated by a physician for the condition for which I am requesting consultation. I understand that treatments through The Center for Reproductive Healing are based upon Traditional Chinese Medical treatments, including Chinese herbal therapy, and that a Traditional Chinese Medical diagnosis does not necessarily replace a Western Medical diagnosis. I am responsible for my own health, which includes seeking out health care options that are appropriate for the condition for which I am seeking treatment. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western medical doctor.

Finally, I know that I am free to incorporate the advice of a Western medical doctor into my healthcare regimen, and if I do so, is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



# The Center For Reproductive Healing

# Medical History

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NAME (LAST, FIRST, MIDDLE)	DATE
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MAJOR COMPLAINT / HEALTH PROBLEM

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HOW DID THIS CONDITION DEVELOP?

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HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
WHAT WERE THE RESULTS OF THE TREATMENT?	

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD:	
DATE	PROBLEM / SURGERY
_____	_____
_____	_____
_____	_____

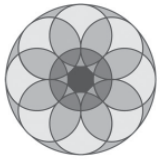
SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

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SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	



# The Center For Reproductive Healing

# Health History

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Please check any symptoms you currently have or have had in the past year.

## General

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

## Head & Neck

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision – see halos

## Respiratory

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production

- Difficulty inhaling
- Difficulty exhaling

## Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

## Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Poor appetite
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

## Diet/Lifestyle

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

## Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

## Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

## Musculoskeletal

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

## Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

## Neurologic

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures

- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

## Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

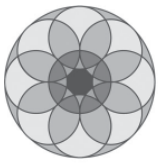
## Men Only

- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Low sexual energy

## Women Only

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy periods
- <25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Low sexual energy
- Vaginal discharges
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant





Have you had fertility treatments?  Yes  No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

Have you taken medication to help you ovulate?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

Have your fallopian tubes been evaluated medically?  Yes  No

What were the results? \_\_\_\_\_

Have you had any tubal operations?  Yes  No

Have you had any hormone laboratory tests performed?  Yes  No

What were the results? \_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

Has he had a fertility workup?  Yes  No

What were the results? \_\_\_\_\_

Is your partner supportive of your wish to conceive?  Yes  No

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  Yes  No

With what? \_\_\_\_\_

Do you use vaginal lubricants?  Yes  No

Are you more than 20% over your ideal body weight?  Yes  No

Are you more than 20% below your ideal body weight?  Yes  No

Do you have a stressful occupation?  Yes  No

Do you exercise regularly?  Yes  No

Do you have excessive facial hair?  Yes  No

Do you have excessively oily skin?  Yes  No

Have you experienced excessive loss of head hair?  Yes  No

Have you noticed discharge from your nipples?  Yes  No

Was your mother exposed to  
diethylstilbestrol (DES) when she was pregnant with you?  Yes  No

Have you been exposed to any  
known environmental toxins or hormones?  Yes  No

Are you presently taking steroids?  Yes  No

COMMENTS/NOTES