FERTILE GROUND

PATIENT INFORMATION

Thank you for choosing Fertile Ground!

It is an honor to work with you on your personal health journey.

The answers you will provide on these forms, along with the information collected during your visits to the clinic and discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and heath concerns. This holistic view allows your concerns to be addressed from a specific *branch* level, but also at a deeper *root* level.

Please take time to thoughtfully and honestly answer these questionnaires so that the picture of your health and health concerns are revealed as clearly as possible.

Name (Last, First, Middle)			Today's Date
Age	Date Of Birth	Sex ❑ Male ❑ Female	Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Phone		Email Address	
Home Address			
City		State	Zip
Occupation		Business Phone	
Employed By			
Spouse's Name			
Emergency Contact		Relationship	Phone

Additional Information

FERTILE GROUND

MEDICAL HISTORY

Name (Last, First, Middle)	Today's Date

Major Complaint/Health Problem

How Long Has This Condition Persisted?

How Did This Condition Develop?

Is There Anything That Makes It Better?

Is There Anything That Makes It Worse?

Have You Ever Received Treatment For This Condition? ❑ Yes ❑ No	If Yes, When?
Where?	By Whom?
What Was The Diagnosis?	What Kinds Of Treatment?

What Were The Results Of The Treatment?

List Any Major Surgeries You Have Had

Date	Problem/Surgery

Significant Trauma (Auto Accidents, Falls, Etc)

Childhood Health Concerns (Select All That Apply)

❑ Allergies ❑ Chicken Pox ❑ Frequent Earaches ❑ Premature Birth ❑ Scarlet Fever ❑ _____

❑ Asthma ❑ Frequent Cold/Flu ❑ Frequent Sore Throat ❑ Rheumatic Fever ❑ _____ ❑ _____

Significant Illnesses (Select All That Apply)

❑ Diabetes ❑ Heart Disease ❑ Thyroid Disease ❑ _____

❑ AIDS ❑ Arthritis ❑ Autoimmune Disease ❑ Gallstones ❑ Hepatitis ❑ Venereal Disease ❑ _____

❑ Appendicitis ❑ Asthma ❑ Cancer ❑ Hypertension ❑ Kidney Stones ❑ Seizures ❑ _____

FERTILE GROUND

HEALTH HISTORY

Name (Last, First, Middle)	Today's Date

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

Temperature
- ❑ Tend to feel hot
- ❑ Tend to feel cold
- ❑ Hot flashes
- ❑ Acute chills
- ❑ Acute fever

Energy
- ❑ Too much/nervous
- ❑ Good energy
- ❑ Okay energy/slightly low
- ❑ Low energy/fatigue

Thirst
- ❑ Thirsty & drink cold
- ❑ Thirsty & drink hot
- ❑ Thirsty, but don't drink
- ❑ Not thirsty

Perspiration
- ❑ Sweat with little exertion
- ❑ Night sweats
- ❑ Can't sweat

Head & Senses
- ❑ Naturally poor vision (without correction)
- ❑ Red/itchy eyes
- ❑ Poor hearing
- ❑ Ear ringing
- ❑ Earaches
- ❑ Frequent Headaches
- ❑ Migraines
- ❑ Sinus/nasal problems
- ❑ Poor sense of smell
- ❑ Frequent sore throats
- ❑ Poor teeth
- ❑ Mouth/tongue sores
- ❑ Lip sores
- ❑ Dry/chapped lips
- ❑ Dry mouth & throat
- ❑ Dizzy/lightheaded
- ❑ Fainting
- ❑ Heavy-headedness
- ❑ Seizures/convulsions

Sleep
- ❑ Insomnia
- ❑ Excessive sleep
- ❑ Difficulty falling to sleep
- ❑ Difficulty staying asleep
- ❑ Lots of vivid dreams
- ❑ Disturbing dreams
- ❑ Sleepwalk/sleeptalk
- ❑ Do not get enough sleep

Lungs & Heart
- ❑ Wheezing
- ❑ Cough
- ❑ Short of breath
- ❑ Frequent colds
- ❑ Seasonal allergies
- ❑ Slow heart rate
- ❑ Fast heart rate
- ❑ Irregular heart rhythm
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ High blood pressure
- ❑ Low blood pressure

Musculoskeletal & Extremities
Pain, weakness, numbness in:
- ❑ Head
- ❑ Neck
- ❑ Shoulders
- ❑ Arms/elbows
- ❑ Wrists
- ❑ Hand/fingers
- ❑ Upper/mid back
- ❑ Lower back
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Ankles
- ❑ Feet/toes
- ❑ Joint swelling
- ❑ Varicose Veins
- ❑ Cold hands and feet
- ❑ All over body pain
- ❑ Restricted movement
- ❑ Broken bones
- ❑ Bone deformities
- ❑ Paralysis

Appetite & Digestion
- ❑ Excessive appetite
- ❑ Poor appetite
- ❑ Excessive saliva
- ❑ Dry mouth
- ❑ Feel a "lump in throat"
- ❑ Abdominal pain
- ❑ Stomachaches
- ❑ Bloating/distention
- ❑ Gas
- ❑ Belching/hiccups
- ❑ Heartburn/reflux
- ❑ Nausea/vomiting
- ❑ Constipation
- ❑ Loose stool/diarrhea
- ❑ Alternating loose & constipation
- ❑ Cramps with BM
- ❑ Unsatisfying BM
- ❑ Hemorrhoids
- ❑ Bowel incontinence

Genitourinary
- ❑ Clear urine
- ❑ Dark urine
- ❑ Cloudy urine
- ❑ Burning urine
- ❑ Scanty urine
- ❑ Profuse urine
- ❑ Frequent urination
- ❑ Wake at night to urinate
- ❑ Incontinence
- ❑ Frequent UTIs
- ❑ Bladder prolapse

Diet & Lifestyle
- ❑ Poor diet
- ❑ Smoke cigarettes
- ❑ Drink alcohol
- ❑ Use drugs
- ❑ Too little activity/exercise
- ❑ Exercise excessively
- ❑ Eating disorder
- ❑ Job stress/concerns
- ❑ Family stress/concerns
- ❑ Other stress/concerns

Mental & Emotional
- ❑ Forgetful/poor memory
- ❑ Poor concentration
- ❑ Irritable/angry
- ❑ Sad
- ❑ Tearful/weepy
- ❑ Anxious/worried
- ❑ Can't stop thinking
- ❑ Fearful
- ❑ Manic
- ❑ Depressed
- ❑ Difficulty expressing emotions
- ❑ Frequently sigh or yawn

Skin Hair & Nails
- ❑ Thick/scaly skin/nails
- ❑ Thin skin/nails
- ❑ Dry skin/nails
- ❑ Easily bruises
- ❑ Dark undereyes
- ❑ Discolored skin
- ❑ Lumps
- ❑ Acne
- ❑ Abscesses/infections
- ❑ Nail fungus
- ❑ Prematurely gray hair
- ❑ Hair loss
- ❑ Dry/brittle hair

Family History
- ❑ Autoimmune disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High/low blood pressure
- ❑ Fertility concerns
- ❑ Thyroid disorder
- ❑ Mental illness

FERTILE GROUND

WOMEN'S HEALTH HISTORY (1 of 2)

Name (Last, First, Middle)	Today's Date

Menstrual History

Age at which menses began _____

Do you menstruate regularly? ❑ Yes ❑ No

If yes, your cycle is _____ days total

Do you menstruate irregularly? ❑ Yes ❑ No

If yes, your cycle varies from _____ to _____ days

When was your last menstrual period? _____

**Note: If you are post-menopausal, please answer the following questions to the best of your recollection.*

Have your cycles changed since they began? ❑ Yes ❑ No

How? _____

Do you know if you ovulate? ❑ Yes ❑ No

If yes, on what day? _____

How do you know? _____

_____

_____

Do you have PMS symptoms? ❑ Yes ❑ No

If yes, check all that apply: ❑ Acne

❑ Bowel Changes ❑ Breast Changes

❑ Cramp/Backache ❑ Food Cravings

❑ Irritability/Anger ❑ Nausea ❑ Sad/Weeping

❑ Others _____

Do you experience cramps ❑ Before ❑ During ❑ After menstruation?

How many days per cycle do you menstruate? _____

Do you spot between periods? ❑ Yes ❑ No

During your period, the flow is:

❑ Light/Spotting on days _____

❑ Medium on days _____

❑ Heavy on days _____

❑ With clots on days _____

What color is the blood?

❑ Light Red on days _____

❑ Bright Red on days _____

❑ Dark Red on days _____

❑ Purple on days _____

❑ Brown on days _____

❑ Black on days _____

Do you have symptoms just after menstruation? ❑ Yes ❑ No

If yes, check all that apply: ❑ Dizziness ❑ Fatigue

❑ Insomnia ❑ Night sweats ❑ Others _____

Do you experience any of the following? ❑ Day sweats

❑ Hot Flashes ❑ Insomnia ❑ Night sweats ❑ Vaginal Dryness

❑ Others _____

What age did you begin perimenopause? _____

What age did you experience menopause? _____

Reproductive History

What birth control have you used in the past?
(ie. BC Pill, 2001-Present)

_____

_____

_____

_____

_____

_____

_____

_____

Are you currently using birth control? ❑ Yes ❑ No

Are you currently trying to conceive? ❑ Yes ❑ No

If yes, how long have you been trying to conceive? _____

FERTILE GROUND

WOMEN'S HEALTH HISTORY (2 of 2)

Name (Last, First, Middle)	Today's Date

Reproductive History (cont.)

How is your sexual energy? ❑ High ❑ Medium ❑ Low

How is your partner's sexual energy? ❑ High ❑ Medium ❑ Low

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____

Have you had any high-risk pregnancies? ❑ Yes ❑ No

Have you had difficult labor/deliveries? ❑ Yes ❑ No

Have you had postpartum concerns? ❑ Yes ❑ No

Have you had lactation concerns? ❑ Yes ❑ No

Breast Health

Do you have any of the following? ❑ Breast Lumps/Nodules

❑ Breast Cancer ❑ Breast Tenderness ❑ Inverted Nipples

❑ Nipple Discharge ❑ Mastitis

❑ Family History Of Breast Cancer ❑ Others _____

Date of last mammogram _____

General Gynecology

Do you have chronic vaginal discharge? ❑ Yes ❑ No

Do you get yeast infections regularly? ❑ Yes ❑ No

Have you ever been diagnosed with any of the following?

❑ Cancer Of Reproductive Organs ❑ Cysts ❑ Endometriosis

❑ Fibroids ❑ Pelvic Abnormalities/Adhesions ❑ PID ❑ STDs

❑ Others _____

Date of last pap smear _____

Have you ever had an abnormal pap smear? ❑ Yes ❑ No

Do you have a family history of cancer of the reproductive organs?

❑ Yes ❑ No

Additional Information

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ASSISTED REPRODUCTIVE THERAPIES HISTORY

Name (Last, First, Middle)	Today's Date

Are you currently seeing an infertility specialist? ❑ Yes ❑ No

What type and practitioner name? _____

_____

Have you had a diagnosis relating to infertility? ❑ Yes ❑ No

What was it? _____

_____

_____

_____

_____

_____

Has your partner had a fertility workup? ❑ Yes ❑ No

Has your partner had a diagnosis relating to infertility? ❑ Yes ❑ No

What was it? _____

_____

_____

_____

_____

_____

Have you had fertility treatments? ❑ Yes ❑ No

If yes, when and where? _____

_____

_____

By whom? _____

_____

_____

What types? _____

_____

_____

_____

_____

_____

Medications for gynecological conditions other than contraceptives?

Medication	Reason	When

Are you > 20% over your ideal body weight? ❑ Yes ❑ No

Are you > 20% below your ideal body weight? ❑ Yes ❑ No

Do you have a stressful occupation? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No

Do you feel you have enough emotional support? ❑ 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

Additional Information