Cristina Wood, L.Ac., FABORM
Specializing in Women's Health and Fertility
127 N. Madison Ave Ste 101B Pasadena, CA 91101
P: 626.744.3157 F: 626.744.3158

Personal Information

Name_____ Date _____

Address_____
_____

Circle One: Married Single Partner Divorced Widow DOB_____

Work Phone _____ Home Phone _____

Cell Phone _____ Email _____

Emergency Contact _____Phone_____

Referred By _____

Employment Status (Circle One) Full-Time Part-Time Retired
Unemployed Student

Occupation _____

Family Physician _____ Phone_____

Chief Complaint

Reason for Visit _____

How and when did this occur?_____

Have you consulted with another doctor about this condition? If so, who?
_____

Date _____ Signature _____

Name (Last, First, Middle) Date

_____ _____

Age at which menses began _____
Are your periods painful? __ Yes __ No
How many days do you normally bleed? ____
How heavy is the bleeding? __Light __Normal __Heavy
What color is the blood? __ Light red __ Red __ Dark red __ Purple __ Brown __ Black
Is there clotting? __ Yes __ No
Does your face break out before or during your period? __ Yes __ No
Do your breasts become tender premenstrually? __ Yes __ No
Do you bleed or spot between periods? __ Yes __ No
Are your menstrual cycles spaced irregularly? __ Yes __ No
How many days are there from one period to the next? ____
Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children have you had?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D & C been performed?	_____	_____

Have you ever had an abnormal pap smear? __ Yes __ No
Have you ever had a cervical biopsy, operation, cauterization or conization? __ Yes __ No
Have you ever had a venereal disease? __ Yes __ No
Do you get yeast infections regularly? __ Yes __ No
Have you ever been diagnosed with a chlamydial infection? __ Yes __ No
Do you have chronic vaginal discharge? __ Yes __ No
Have you ever had pelvic inflammatory disease? __ Yes __ No
Were you treated for it? __ Yes __ No
How? _____
Date of last pap smear _____
Have you ever been diagnosed with uterine fibroids or polyps? __ Yes __ No
Have you ever been diagnosed with endometriosis? __ Yes __ No
Have you been diagnosed with any pelvic abnormalities? __ Yes __ No
Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you cycles changed since they began? ___Yes ___No
How? _____
Do you ovulate on your own? ___Yes ___No
On what day of your cycle? ____
Do your breasts get tender at/during ovulation? ___Yes ___No
Do you get premenstrual low back pain? ___Yes ___No
Do you have nay sores on your genitalia? ___Yes ___No
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 are 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

Have you taken oral contraceptives? ___Yes ___No

When? _____ How long? _____

Have you ever had an IUD? ___Yes ___No

When? _____ How long? _____

Have you ever taken DepoProvera? ___Yes ___No

When? _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ___Yes ___No

What was it? _____

Do your bowel movements become loose at the beginning of your period? ___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% under 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 ever been exposed to any known environmental toxins or hormones? ___Yes ___No

Are you presently taking steroids? ___Yes ___No

Do you have lower back weakness, soreness, or pain, or knee problems? ___Yes ___No
Do you have ringing in your ears or dizziness? ___Yes ___No
Does your hair prematurely gray? ___Yes ___No
Do you have vaginal dryness? ___Yes ___No
Is your midcycle fertile cervical mucus scanty or missing? ___Yes ___No
Do you have dark circles around or under your eyes? ___Yes ___No
Do you have night sweats? ___Yes ___No
Are you prone to hot flashes? ___Yes ___No
Would you describe yourself as afraid a lot? ___Yes ___No

Do you have premenstrual lower back pain? ___Yes ___No
Is your low back sore or weak? ___Yes ___No
Are your feet cold, especially at night? ___Yes ___No
Are you typically colder than those around you? ___Yes ___No
Is your libido low? ___Yes ___No
Are you often fearful? ___Yes ___No
Do you wake up at night or early in the morning because you have to urinate? ___Yes ___No
Do you urinate frequently, and is the urine diluted and/or profuse? ___Yes ___No
Do you have early morning loose, urgent stools? ___Yes ___No
Do you have profuse vaginal discharge? ___Yes ___No
Does your menstrual blood tend to be dull in color? ___Yes ___No
Do you feel cold cramps during your period that respond to a heating pad? ___Yes ___No

Are you often fatigued? ___Yes ___No
Do you have poor appetite? ___Yes ___No
Is your energy lower after a meal? ___Yes ___No
Do you feel bloated after eating? ___Yes ___No
Do you crave sweets? ___Yes ___No
Do you have loose stools, abdominal pain, or digestive problems? ___Yes ___No
Are your hands and feet cold? ___Yes ___No
Is your nose cold? ___Yes ___No
Are you prone to feeling heavy or sluggish? ___Yes ___No
Are you prone to feeling heaviness or grogginess in the head? ___Yes ___No
Do you bruise easily? ___Yes ___No
Do you think you have poor circulation? ___Yes ___No
Do you have varicose veins? ___Yes ___No
Are you lacking strength in your arms and legs? ___Yes ___No
Are you lacking in exercise? ___Yes ___No
Are you prone to worry? ___Yes ___No
Have you been diagnosed with low blood pressure? ___Yes ___No
Do you sweat a lot without exerting yourself? ___Yes ___No
Do you feel dizzy or light-headed, or have visual changes when you stand up fast? ___Yes ___No
Is your menstruation thin, watery, profuse or pinkish in color? ___Yes ___No

Are you more tired around ovulation or menstruation? ___Yes ___No
Do you ever spot a few days or more before your period comes? ___Yes ___No
Have you ever been diagnosed with uterine prolapse? ___Yes ___No
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus? ___Yes ___No
Are you often sick, or do you have allergies? ___Yes ___No
Have you ever been diagnosed with hypothyroid or anemia? ___Yes ___No
Do you have hemorrhoids or polyps? ___Yes ___No

Are your menses scanty and/or late? ___Yes ___No
Do you have dry, flaky skin? ___Yes ___No
Are you prone to getting chapped lips? ___Yes ___No
Are your fingernails or toenails brittle? ___Yes ___No
Are you losing hair on your head (not in patches, but all over)? ___Yes ___No
Is your hair brittle or dry? ___Yes ___No
Do you have diminished nighttime vision? ___Yes ___No
Do you get dizzy or light-headed around your period? ___Yes ___No

Is your menstrual flow ever brown or black in color? ___Yes ___No
Do you feel midcycle pain around your ovaries? ___Yes ___No
Do you have painful, unmovable breast lumps? ___Yes ___No
Do you experience periodic numbness of your hands and feet (especially at night)? ___Yes ___No
Do you have varicose or spider veins? ___Yes ___No
Do you have red hemangiomas (cherry red spots) on your skin? ___Yes ___No
Does your complexion appear dark and “sooty”? ___Yes ___No
Do you have chronic hemorrhoids? ___Yes ___No
Does your menstrual blood contain clots? ___Yes ___No
Have been diagnosed with endometriosis or uterine fibroids? ___Yes ___No
Is your lower abdomen tender to palpation (resisting touch)? ___Yes ___No
Can you feel any abnormal lumps in your lower abdomen? ___Yes ___No
Do you have any piercing or stabbing menstrual cramps? ___Yes ___No
Are the veins beneath your tongue twisty and tortuous? ___Yes ___No
Do you have dark spots in your eyes? ___Yes ___No
Have you been diagnosed with any vascular abnormality or blood clotting disorder? ___Yes ___No

Liver Qi Stagnation (Lv Qi X)
Are you prone to emotional depression? ___Yes ___No
Are you prone to anger and/or rage? ___Yes ___No
Do you become irritable premenstrually? ___Yes ___No
Do you feel bloated or irritable around ovulation? ___Yes ___No
Doe sit feel as if your ovulation lasts longer than it should? ___Yes ___No
Are your breasts sensitive/sore at ovulation? ___Yes ___No
Do you experience nipple pain or discharge from your nipples? ___Yes ___No
Do you have a lot of premenstrual breast distension or pain? ___Yes ___No

Have you been diagnosed with elevated prolactin levels? ___Yes ___No
Do you become bloated premenstrually? ___Yes ___No
Are your pupils usually dilated and large? ___Yes ___No
Do you have difficulty falling asleep at night? ___Yes ___No
Do you experience heartburn or wake up with a bitter taste in your mouth? ___Yes ___No
Are your menses painful? ___Yes ___No
Do you feel your menstrual cramps in the external genital area? ___Yes ___No
Is your menstrual blood thick and dark, or purplish in color? ___Yes ___No

Do you wake up early in the morning and have trouble getting back to sleep? ___Yes ___No
Do you have heart palpitations, especially when anxious? ___Yes ___No
Do you have nightmares? ___Yes ___No
Do you seem low in spirit or lacking in vitality? ___Yes ___No
Are you prone to agitation or extreme restlessness? ___Yes ___No
Do you fidget? ___Yes ___No
Is the tip of your tongue red? ___Yes ___No
Do you sweat excessively, especially on your chest? ___Yes ___No

Is your pulse rate rapid? ___Yes ___No
Is your mouth and throat usually dry? ___Yes ___No
Are you thirsty for cold drinks most of the time? ___Yes ___No
Do you often feel warmer than those around you? ___Yes ___No
Do you wake up sweating or have hot flashes? ___Yes ___No
Do you break out with red acne (especially premenstrually)? ___Yes ___No
Do you have a short menstrual cycle? ___Yes ___No
Do you have vaginal irritation or rashes? ___Yes ___No

Do you feel tired and sluggish after a meal? ___Yes ___No
Do you have fibrocystic breasts? ___Yes ___No
Do you have cystic or pustular acne? ___Yes ___No
Do you have urgent, bright, or foul-smelling stools? ___Yes ___No
Does your menstrual blood contain stringy tissue or mucus? ___Yes ___No
Are you prone to yeast infections and vaginal itching? ___Yes ___No
Do your joints ache, especially with movement? ___Yes ___No
Are you overweight? ___Yes ___No
Do you have signs of heat and/or dampness as indicated above? ___Yes ___No
Do you have foul-smelling, yellow, or greenish vaginal discharge? ___Yes ___No
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? ___Yes ___No