***Medical History – thank you for filling this out as completely as possible*.** **Today's Date:**

Legal Name:	**DOB:**	**Age:**
Street:	**Ht.:**	**Wt.:**
City/State/Zip:	**Cell:**	**Home:**
Occupation:	**Email:**	
Main Complaint:		**Date of Onset:**
Primary Care Physician:	**Midwife:**	
Ob/Gyn:	**Reprod. Endocrinologist:**	
Other concurrent therapies:		
Insurance Co.:	**Mbr #:**	
Marital status: ☐ Single ☐Married ☐Separated ☐Divorced ☐ Widowed ☐ Partnered		
Emergency contact & phone:		

Surgeries & dates (tonsillectomy, etc. NOTE: see page __ for reproductive surgeries):
Trauma (auto accidents, falls, etc.) & dates:
Current Allergies (drugs, chemicals, foods, etc):
Medicines/Supplements & dosages taken within the last two months:
Rest/rejuvenation routine: ☐ Sleeping ☐Exercise ☐Yoga ☐Qi Gong/Tai Chi ☐Meditation ☐Visualization ☐Prayer ☐Sex ☐Massage ☐Energy Work ☐Hobbies (reading, gardening, sky watching, cleaning, dancing, etc.) ☐TV ☐Internet ☐Movies ☐Art/Performance ☐Spending time with friends/family ☐Eating ☐Other:
Exercise routine:
Average daily meals (pls list times and foods): Snacks: Breakfast: _____ AM Lunch: _____AM/PM Dinner: _____PM _____ _____ _____ _____ _____ _____ _____ _____ _____ **Thirst:** ☐low ☐high ☐normal **Prefers drinking:** ☐Cold ☐Warm ☐Room temp **Amount of water per day:** _____oz/liter/gall.
Personal Habits *(current & past)*: ☐Coffee #Cups daily:____ ☐Tea #Cups daily:____ ☐Soda # daily:____ ☐Alcohol #wkly:_____ ☐Sugar ☐Salt ☐Cigarettes #daily:____ ☐Recreational drugs: _____ **Any addictions you'd like to quit?** _____ **Motivation level to quit** (1:low; 10:high): _____
Family History (parents, siblings): Addictions Alzheimer's/Dementia Allergies Auto-Immune Cancer Diabetes High Blood Pressure Heart Disease Stroke Seizure Other:

Medical Diagnoses & Dates:

Addiction	Gallstones/Kidney stones	Nervous disorder
Allergies (chronic)	Hernia	Nodules/lipomas/cysts
Alzheimer's/Dementia	Heart Disease / high cholesterol	Renal (kidney) Disease
Anemia	Bleeding/Hemorrhage	Respiratory disease
Arthritis	Hypertension	Rheumatic fever
Autoimmune	Hepatitis	Root Canal
Cancer	HIV/AIDS	Shingles
Chicken pox	Kidney disease	STDs
Chronic Fatigue	Lyme	Stroke
Colds, flus, sinus infections	Liver disease	Tuberculosis
Diabetes	Mental Illness	Thyroid
Digestive (IBS, Crohns)	Mononucleosis	Vein condition (varicose, etc.)
Fibromyalgia	Mumps	Other:

Digestive

Appetite: ☐Normal ☐Low ☐ Heavy ☐Hard to feel satisfied ☐Anorexia ☐ Bulimia
Cravings: ☐alcohol ☐breads ☐cookies ☐ice cream ☐potato chips ☐chocolate ☐other:_____
Flavors: ☐salty ☐sour ☐bitter ☐sweet ☐spicy **Digestion:** ☐gas ☐bloating ☐pain ☐fatigue after eating
☐gurgling intestines ☐indigestion ☐hypoglycemia ☐burping ☐hiccups ☐reflux ☐nausea/vomiting ☐ bad breath

Bowel/Stool: ☐Formed ☐Soft ☐Diarrhea ☐Hard ☐Alternating consistency ☐Pellets ☐Incomplete
Amount: 12"-18" daily? ☐yes ☐no **Frequency:** ☐Daily 1-2x ☐Daily 3-5x ☐Not daily: how often___
Laxative use:_____ **# per week:**_____ **BM Color:** ☐Brown ☐Light ☐Black
Mucus: ☐Yes ☐No ☐scant ☐Profuse **Bowel Movement:** ☐Pain ☐Straining ☐Burning
Hemorrhoids: ☐Piles ☐Pain ☐Itching ☐Bleeding **Ulcer:** ☐yes ☐no **Hiaital Hernia:** ☐yes ☐no
Intestinal Polyps: ☐yes ☐no Other:_____

Musculoskeletal

Location of pain/discomfort: ☐Head ☐Neck ☐Lumbar ☐Sacrum ☐Shoulder ☐Upper back
☐Midback ☐Elbow ☐Knee ☐Feet ☐Hands ☐Ribcage
Pain style: ☐Sharp ☐Aching ☐Dull ☐Throbbing ☐Burning ☐Pressure ☐Tight ☐Numbness/Tingling
Radiating: *Pls. describe where pain radiates to*: _____
Onset: ☐Gradual ☐Acute **Wakes me at night:** ☐ yes ☐no **Accompanied by weight loss:** ☐yes ☐no
Duration: ☐Chronic ☐Intermittent **If intermittent, how long does it last:** ____ minutes / hours / days
Accompanying symptoms: ☐Swelling ☐Redness ☐Other
What makes it worse: ☐Heat ☐Cold ☐Rain ☐Low pressure system ☐Movement ☐Rest ☐ Massage
What makes it better: ☐Heat ☐Cold ☐Rain ☐Low pressure system ☐Movement ☐Rest ☐Massage

General

Body temp: ☐Cold ☐Hot ☐Normal **Location:** *Indicate H=hot or C=cold* ___Core ___Feet ___Hands
___Lumbar ___Knees ___Abdomen ___Genitals ___Hips ___Buttocks ___Chest

Hot flashes: ☐Day ☐Night **With sweating:** ☐yes ☐no **# weekly:**

Sweating: ☐Lack of perspiration ☐Perspires easily ☐Normal **Amount:** ☐Mild ☐Profuse
☐Cold afterwards **Location:** ☐palms ☐feet ☐chest ☐back ☐neck ☐head ☐whole body

Energy level: 1 to 10 (1=can't get out of bed; 10: excellent)_____ **Sudden drop at** _____ (time)
☐Easily fatigued ☐Lethargic ☐Unmotivated

Sleep: Avg. nightly hours: _____ **Wakes feeling rested:** ☐ yes ☐no
Time it takes to fall asleep: _____ **# waking in the night:** _____ **at what time:** _____ ☐**Wakes to pee**
Wakes feeling: ☐ restless ☐afraid ☐anxious ☐active mind **If waking, easy to back asleep?** ☐yes☐no

Skin and Hair

Skin: ☐Dry ☐Itching ☐Hives ☐Rashes ☐Dermatitis ☐Eczema ☐Psoriasis ☐Ulcerations ☐Boils
☐Acne ☐Dandruff ☐Changing moles or skin ☐Warts
Hair: ☐Dry ☐Oily ☐Hair loss ☐Early graying ☐Changes in hair
Nails: ☐ weak, dry, brittle ☐ little or no white 'crescent' at base of nailbed ☐white flecks

Head, eyes, nose, throat

Head: ☐Memory ☐Mental fog or sluggishness ☐Poor focus ☐Dizziness/Vertigo ☐Concussion ☐Traumatic Brain Injury ☐Headaches ☐Migraines ☐Balance & Coordination problems ☐Tremors ☐Twitches ☐Seizures ☐Peculiar tastes/smells
Eyes: ☐Poor vision ☐Floaters ☐Redness ☐Itchy ☐Dryness ☐Pain ☐Strain ☐Night blindness ☐Glaucoma ☐Macular degeneration ☐Other:
Ears: ☐Hearing loss ☐Deafness ☐Tinnitus/ringing ☐Earaches Which ear: ☐Left ☐Right ☐Both
Nose: ☐Sinus infections ☐Dryness ☐Nosebleeds ☐Poor smell ☐No smell
Jaw: ☐TMJ ☐Clicking ☐Grinding teeth
Teeth: ☐Root canals ☐Cavities ☐Weak teeth ☐Implants #____ ☐Bridges #_____
Mouth/Throat: ☐Dry lips ☐Cracking corners of the mouth ☐Cold sores ☐Canker sores ☐ Tongue tenderness ☐Dry mouth ☐copious saliva ☐swollen/bleeding gums ☐Lump in throat

Emotional-Mental

Check all that apply: ☐Moodiness ☐Anxiety ☐Panic ☐Depression ☐Grief-Sadness ☐Anger ☐Irritability ☐Frustration ☐Fear ☐Worry ☐Agitation ☐Obsessiveness ☐Timidity ☐Reclusiveness ☐Giddiness ☐Bad Temper ☐Easily overwhelmed by stressful circumstances ☐Jumpy or easily frightened **Are any of these emotions new or recently increased in frequency?** ☐yes ☐no
What degree of stress are you experiencing? (1=low; 10=high): _____ **What areas of your life are most stressful (all that apply):** ☐Health ☐Work ☐Partner/Spouse ☐Family ☐Money ☐Friends Other:_____ **How does stress affect your:** Emotions: _____ Health: _____ Actions/Behavior: _____Thoughts & attitudes: _____
History of mental illness (including medical diagnoses):

Cardiovascular

Chest pain: ☐yes ☐no **Radiating pain from chest to neck or arm:** ☐yes ☐no **Palpitations:** ☐yes ☐no
Blood pressure: ☐high ☐low **Dizziness upon rising from seated position:** ☐yes ☐no
High cholesterol: ☐yes ☐no **Difficulty breathing:** ☐yes ☐no **Sweats easily:** ☐yes ☐no
Irregular heartbeat: ☐yes ☐no **Heart murmur:** ☐yes ☐no
Hands & Feet: ☐Cold ☐Hot ☐Normal **Swelling:** ☐yes ☐no
Blood clots: ☐yes☐no **Phlebitis:** ☐yes☐no **Varicose/spider veins:** ☐yes☐no **Bruises easily:** ☐yes☐no

Respiratory

Cough: ☐mild ☐forceful ☐dry ☐wet ☐bloody **Difficult breathing** ☐wheezing ☐shortness of breath ☐Asthma ☐Bronchitis ☐Pneumonia ☐Emphysema **Worse with** ☐Lying down ☐Exertion ☐Other:_____
Phlegm: ☐mild ☐ profuse ☐thin/slippery ☐thick/sticky ☐clear ☐white ☐yellow ☐green ☐brown

Urinary

Urination Frequency daily: ☐<4x ☐5-10x ☐>11x **Amount:** ☐Small ☐Profuse ☐Normal
Color: ☐straw yellow ☐dark yellow ☐clear/very pale ☐brown ☐reddish **Clarity:** ☐cloudy ☐oily
☐Pain/burning ☐Urgency ☐Slow ☐Dribbling ☐Leaking **Kidney stones:** ☐yes ☐no

Female Reproduction & Sexual Wellbeing

Age of 1st menses: ____ Date of last menses: _____ Menopause: ☐yes ☐no (if yes, skip to next section)

#Days in avg. cycle, from 1st day of last period to the day before new period: ____
If irregular, shortest # days: ___ Longest #: ___ Menstrual Flow: ☐light ☐normal ☐heavy
 # Days of strongest flow: _____ # Days of spotting: _____# pads/tampons/diva cups daily: _____
Menstrual Color: ☐pale ☐bright red ☐normal red ☐dark red ☐dark purple ☐brown
Clots#: ☐<5 ☐6-10 ☐>15 **Size***:* ☐ 'dime' ☐ 'nickel' ☐ 'quarter' ☐'half dollar+' **Mucus:** ☐yes ☐no
Pain: ____ (1: mild - 10 worst) ☐dull ☐cramping **Location:** ☐abdomen ☐back ☐legs ☐head ☐breasts
Bowel changes with menses: ☐loose ☐constipation **Emotions/PMS**: ☐yes ☐no **Describe:** _____

Mid-cycle: ☐pain ☐spotting **Mid-cycle cervical mucus that is stretchy, clear and generous:** ☐yes ☐no
Ovulation occurs at cycle day #_____

Other vaginal discharge: ☐yes ☐no **Color:** ☐white ☐yellow ☐brown ☐pink/red **Smell:** ☐mild ☐strong

Sexually active: ☐yes ☐no **Libido:** ☐low ☐normal ☐high **Fatigue after sex:** ☐yes ☐no
Vaginal pain: ☐yes ☐no **Worse with intercourse:** ☐yes ☐no **Lubrication:** ☐dry ☐moist
Vaginal sores: ☐yes ☐no **Date of last PAP: _____**
History of STDs: ☐HPV ☐Genital Herpes ☐Pelvic Inflammatory Disease ☐Chlamydia ☐Gonorrhea ☐Syphilis ☐HIV/AIDS **Tested for chlamydia:** ☐yes ☐no **Results:** ☐positive ☐negative

History of birth control: ☐OCP #yrs:____ ☐IUD #yrs:____ ☐Condoms #yrs:____ Other:_____

Date of last breast self-exam: **Breast lumps/pain:** ☐yes ☐no **Nipple discharge:** ☐yes ☐no

Female Fertility
Years trying to conceive: _____
 # Pregnancies: _____ # Cesarean births: _____ # Vaginal births: _____ # Abortions: _____
 # Miscarriages: _____ # Ectopic(s): _____ # premature births: _____
Difficulty with pregnancy/labor (pls describe): _____
#Failed IUI's: _____ # Failed IVF's: _____
List the Fertility Drugs you have taken: _____

_____

Previous Gynecological Surgeries:
☐ Dilation & Curettage (D&C) ☐Falloposcopy (HSG) ☐Hysterosalpingogram (HSG) ☐Hysteroscopy
☐ Laparoscopy for endometriosis ☐Laparoscopy for ovarian cysts ☐ Laparoscopy (uterine fibroids)
☐Myomectomy ☐Neosalpingostomy ☐Tuboplasty ☐Others(s):_____

Previous Diagnoses by Ob/Gyn or Fertility Specialist
☐Advanced Maternal Age ☐Amenorrhea ☐Anovulation ☐Anti-Sperm Antibodies
☐Autoimmune Oopharitis ☐Cervical Stenosis ☐Elevated FSH _____
☐Endometriosis (☐mild ☐moderate ☐severe)
☐Erratic Cycles (____ to ____ days) ☐Fallopian Tube Blockage ☐Habitual Miscarriage
☐Hostile Cervical Mucus ☐Hyperprolactinemia ☐Luteal Phase Defect ☐Menorrhagia
☐Ovarian Cyst (single) ☐Ovarian Hyperstimulation Syndrome (OHSS) ☐Pelvic Inflammatory Disease (PID)
☐Phospholipid Antibodies ☐Polycystic Ovarian Syndrome (PCOS) ☐Premature Ovarian Failure (POF)
☐Resistant Ovarian Syndrome ☐Unexplained Infertility ☐Uterine Fibroids ☐Uterine Septum
☐Others(s):_____

Male reproduction & Sexual Wellbeing

Libido: ☐low ☐high **Erectile dysfunction:** ☐yes ☐no **Difficulty ejaculating:** ☐yes ☐no **Retrograde Ejaculation:** ☐yes ☐no **Impotence:** ☐yes ☐no **Testicular swelling:** ☐yes ☐no **Testicular Pain:** ☐yes ☐no **Heat sensation in testicles:** ☐yes ☐no **Testicular/scrotal itching:** ☐yes ☐no **Prostatitis:** ☐yes ☐no **Date of last prostate exam:** _____ **Results:** _____
Penile discharge: ☐yes ☐no **Varicocele** ☐yes ☐no **Epididymitis** ☐yes ☐no **Hernia** ☐yes ☐no
Genetic or chromosomal abnormalities/translocations: _____
_____

History of STDs: ☐HPV ☐Genital Herpes ☐Chlamydia ☐Gonorrhea ☐Syphilis ☐HIV/AIDS

Fertility Date of last sperm analysis:

Do you have any biological children with your partner? ☐ yes ☐ no How many:_____ Ages:_____ Do you have any biological children with previous partner(s)? ☐ yes ☐ no How many:____ Ages: _____

Exams or Procedures:
☐Anti Sperm Antibodies (ASA) ☐IVF with ICSI ☐Sperm Chromatin Structure Assay (SCSA)
☐Sperm Aspiration (MESA/TESA/PESA) ☐Vasectomy ☐Vasectomy Reversal

Global Health – PROMIS Global Health (10) SF

	Please respond to each item by marking <u>One box per row</u>	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
Global 1	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 2	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 3	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 4	In general, how would you rate your mental Health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 5	In general, how would you rate your satisfaction relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 9	In general, please rate how well you carry Out your usual social activities and roles. (This includes activities at home, at work & in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global 6	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carry groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10	How often have you been bothered by Emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 8	How would you rate your fatigue on average?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 7	How would you rate your pain on average?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10 No Pain — Worst Imaginable Pain				

PROMIS Item Bank v2.0 – Companionship – Short Form 4a

		Never	Rarely	Sometimes	Usually	Always
FSE31057x2	Do you have someone with whom to have fun?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FSE31061x2	Do you have someone with whom to relax?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FSE31068x	Do you have someone with whom you Can do something enjoyable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA15x2	Can you find companionship when you want it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS Item Bank v2.0 - Emotional Support – Short Form 4a

		Never	Rarely	Sometimes	Usually	Always
FSE31053x2	I have someone who will listen to me when I need to talk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FSE31059x2	I have someone to confide in or talk to about myself or my problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SS12x	I have someone who makes me feel appreciated	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SSQ3x2	I have someone to talk with when I have a bad day	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS Item Bank v2.0 - Instrumental Support – Short Form 4a

		Never	Rarely	Sometimes	Usually	Always
CCC31052x	Do you have someone to help you if you are confined to bed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CCC31055x	Do you have someone to take you to the doctor if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CCC31065x	Do you have someone to help with your daily chores if you are sick?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SS6	Do you have someone to run errands if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

		Never	Rarely	Sometimes	Usually	Always
UCLA11x2	Do you have someone to help you if you are confined to bed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA13x3	Do you have someone to take you to the doctor if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA14x2	Do you have someone to help with your daily chores if you are sick?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA18x2	Do you have someone to run errands if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5