YX Medical Group, Inc

I. General Patient Information

Name: _____ _____
(First) (Last)

Date of Birth: _____/_____/_____ Sex: ☐ Male / ☐ Female

Address: _____ City_____ State_____ Zip Code:_____

Home Phone#: (_____)_____ Cell Phone#: (_____)_____

Email Address: _____ SS#: _____

DL#: _____ Occupation: _____ Employer: _____

Is this your first time getting acupuncture? ☐ Yes / ☐ No

How did you hear about us? ☐ Friend referral _____ ☐ Lighthouse

☐ Weekly LaLaLa ☐ Vivi Navigation ☐ Yelp ☐ Our Website

Is this visit due to an auto accident? ☐ Yes / ☐ No

Do you have health insurance? ☐ Yes / ☐ No Name of Carrier: _____

Emergency Contact : _____

Relationship: _____ Phone#: (_____)_____

I hereby certify that to the best of my knowledge, all statements contained hereon are true.
I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage.
I furthermore agree to pay legal, interests, collection expense and attorney's fee should it become necessary to assign any amount I may own for collections.
I hereby authorize YX Medical Group, Inc to release information requested by my insurance company for service rendered.
I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO YX MEDICAL GROUP INC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
I have read and understood the "HIPAA Notice of Privacy Practice" and how my medical information may be used and disclosed and how I can get access to this information.
I have read and understood the "Patient Policies" and agree with the policies.
I hereby authorize the Acupuncturist to treat my condition as she/he deems appropriate.
I fully understand that this agreement and consent will continue until cancelled by me in writing.

Date: _____ Patient or Guarantor's Signature _____

Women's Fertility History

Age at which menses began _____

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last? _____

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

Do you have premenstrual tension? ☐ 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 _____(mm/dd/yy)

How many pregnancies have you had? _____Which year?_____

How many children do you have? _____Which year?_____

How many abortions have you had? _____Which year?_____

How many miscarriages have you had? _____Which year?_____

How many times has a D&C been performed? _____Which year?_____

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? _____

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 pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you taken any medications for gynecological conditions other than contraceptives? ☐ Yes ☐ No

Medication	Reason	How long

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

How?_____

On what day of your cycle? ☐ Yes ☐ No

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Do you get premenstrual low back pain? ☐ Yes ☐ No

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No

What types of fertility treatments have you had_____

When and where?_____By Whom?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When and 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?_____

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When and how long?_____

How long have you been trying to conceive? ☐ Yes ☐ No

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

What was it?_____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you use vaginal lubricants? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Have you noticed discharge from your nipples? ☐ Yes ☐ No

Have you been exposed to any known environmental toxins or hormones? ☐ 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

Is your hair prematurely gray? ☐ Yes ☐ No

Do you have vaginal dryness? ☐ Yes ☐ No

Are you prone to hot flashes? ☐ Yes ☐ No

Do you have lower back pain premenstrually? ☐ 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

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 jour menstrual blood lend to be dull in color? ☐ Yes ☐ No

Are you often fatigued? ☐ Yes ☐ No

Do you have poor appetite? ☐ Yes ☐ No

Is your energy lower after a meal? ☐ Yes ☐ No

Are your hands and feet cold? ☐ Yes ☐ No

Have you been diagnosed with low blood pressure? ☐ 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

Have you been diagnosed with hypothyroid or anemia? ☐ Yes ☐ No

Are your menses scanty and/or late? ☐ Yes ☐ No