The Marlborough Wellness Center
Where Modern and Traditional Medicine Become Integrated
277 Main Street, Ste. 208 • Marlborough, MA 01752

Women's Health History And Intake Form

Date: _____
Name (Last, First): _____
Address: _____
City, State, and Zip: _____
Home Phone: _____
Daytime Phone: _____
Emergency Contact Name/Phone: _____
Date of Birth: _____ Age: _____
Occupation: _____
Referred By: _____
Primary Care Physician/Contact #: _____
Email address: _____

Have you been treated by acupuncture or Oriental Medicine before? YES NO
Main concern(s) you would like us to address:
_____
_____
When did this begin? _____
How does it interfere with your daily activities (i.e.: work, sleep, sex)?
_____
Have you been given a diagnosis for this problem?
_____
What other treatments have you tried? _____

Family Medical History (circle all applicable)
Diabetes Cancer High Blood Pressure Heart Disease Stroke
Seizures Asthma Allergies Other:

Past Medical History
Significant Illnesses (circle all applicable and specific dates)
Cancer Diabetes Hepatitis High Blood Pressure Heart
Disease Rheumatic Fever/childhood diseases Thyroid Disease Other:
Surgeries: _____
_____
Significant Trauma (auto accidents, falls, etc.):
_____
_____
Allergies (drugs, metals/chemicals, foods):
_____
Medicines taken in the last 3 months (vitamins, drugs, herbs):
_____
_____

Personal Information

Do you exercise regularly? If yes, please describe:

_____

_____

Have you ever been on a restricted diet? If yes, what kind and why?

_____

_____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you currently smoke? YES NO If yes, how much per day? _____

If no, do you have a history of smoking? YES NO

If yes, how much per day and when did you quit? _____

Please describe any use of drugs for non-medical purposes:

_____

How many caffeinated beverages do you drink per day?

_____

How much water do you drink per day?

_____

How much alcohol do you drink per day?

_____

Are there any other concerns you would like us to address?

_____

_____

_____

_____

_____

In all the areas listed below, please circle if you have experienced any symptoms in the past 3 months:

General

Fevers Sweat easily Bleed or bruise easily Change in appetite

Sudden energy drop (if yes, what time of day?) _____

Poor sleeping/insomnia chills Weight loss/gain Strong thirst

Fatigue Night sweats Cravings (if yes, what? _____

Skin and Hair

Rashes Itching Change in hair/skin texture Ulcerations Eczema Hives

Loss of hair Acne Recent moles other: _____

Head/Eyes/Ears/Nose/Throat

Dizziness Glasses Poor/blurry vision Cataracts Eye strain Eye pain

Eye surgeries (if yes, what? _____) Color Blindness

Floaters (spots in front of eyes) Night blindness Tinnitus (Ringing in ears)

Earaches Poor hearing (hearing aids?)

Headaches/Migraines (if yes, where located? _____)

Sinus problems Teeth grinding Concussions Nose bleeds jaw clicks

Recurrent sore throats Sores on lips/tongue Other: _____

Cardiovascular

Blood pressure: high or low Irregular heartbeat cold hands/feet

History of blood clots difficulty breathing Swelling of hands/feet

Phlebitis chest pain fainting Other: _____

Respiratory

Cough bronchitis difficulty breathing when lying down asthma
Production of phlegm (if yes, what color? _____)
Coughing blood pneumonia pain with deep breath Other: _____

Gastrointestinal

Nausea vomiting diarrhea constipation gas belching black stools
blood in stools indigestion bad breath rectal pain hemorrhoids
bleeding gums abdominal pain/cramps chronic laxative use other: _____

Genitourinary

Pain upon urination frequent urination blood in urine urgency to urinate
unable to hold urine night urination (if yes, how frequently? _____)
Kidney stones decrease in flow impotency sores on genitals other: _____

Gynecological History (circle if applicable)

Sexually transmitted diseases: (please list) _____
Infections injuries to the genitalia genital surgeries
Genital cysts herpes genital warts

Menstruation

Onset: (age) _____
Is your menstrual cycle on a regular schedule? **Yes no**
Was your menstrual cycle ever regular? **Yes no** If yes, when? _____
Does it tend to be late or early? _____
Does it alternate between late and early? **Yes no**
Do you have spotting in between periods? **Yes no**
What is the length of your period in days? _____

Color of menstrual blood (circle the average one you experience)

Dilute/pale red bright red dark red purple brown black

Consistency of menstrual blood (circle one)

Thin/dilute thick mucous-like moderate/normal
Is there mucous in your menstrual blood flow? **Yes no**

Smell of menstrual blood

Is there a specific smell to your menstrual blood? (please explain)
_____

Presence of clots

Do you experience blood clots in your menstrual flow? **Yes no**
How many clots would you estimate you find per period? **Many A few**
What size are they? (circle the one you experience)
Quarter dime nickel very small golf ball
Do they have a color? **Yes no** If yes, what color(s)? _____

Vaginal discharges

Do you have any vaginal discharges? **Yes no**
If yes, primarily when and how much? _____
Is there a specific odor? (circle one) leathery fishy other: _____
What is the color of the vaginal discharges? (circle all that apply)
Clear white yellow green blood-tinged
Do they cause vaginal itching? **Yes no**
Does anything alleviate the itching? **Yes no**
If yes, what? _____
Does it have a specific consistency? _____

Pain during menses

Do you experience pain during menses? **Yes no**
If yes, when do you experience the pain? (circle all that apply)
Before after during
What is the location of the pain? (circle all that apply)
Upper abdomen/under the ribcage lower abdomen low back

What is the nature of the pain? (circle all that apply) sharp dull
Is it better with or alleviated by: (circle all that apply)
heat cold massage rest activity

Clinical manifestations
What signs and symptoms below do you experience throughout your menstrual cycle? (**NOTE:** please place a **circle** around those signs you feel *before* the period, a **square** around those you feel *during* the period, and **underline** those you feel *after* the period is done)

Abdominal pain Low back discomfort cramps in low abdomen area
headaches/migraines sore/tight muscles poor memory
changes in urination (increased/decreased frequency, color, etc.)
dizziness dry eyes floaters changes in body temp (hot/cold)
changes in sexual desire (increase/decrease) breast tenderness
tiredness irritability mood swings weepiness Night sweats
sleep disturbances water retention vaginal discharges
difficulty breathing clumsiness Other: _____

Reproductive History
Are you currently pregnant? **Yes no**
Is it possible you could be pregnant? **Yes no**
Have you ever been pregnant? **Yes no**
How many? _____ # of vaginal pregnancies: _____ # Cesarean: _____
Was the labor(s) complicated or abnormal in any way? (please explain)
_____
_____
Any miscarriages? **Yes no #:** _____
Any abortions? **Yes no #:** _____
How many months into the pregnancy was the miscarriage? _____
Do you have a history of breast-feeding? **Yes no**
If yes, did you have any difficulties with lactation, etc.? **Yes no**
(please explain) _____
Do you have a history of infertility? **Yes no**
If yes, what therapies/treatments did you utilize? (please explain)
_____

Have you ever taken oral contraception (birth control pill)? **Yes no**
If yes, How long? _____ When did you start? _____
Are you currently using oral contraception? **Yes no**
If no, when did you stop taking the birth control? _____
Did you notice any changes in your menstrual cycle when you did stop taking the oral contraception? (please explain) _____

Musculoskeletal (please circle areas where you experience pain)
Neck back/spine hand/wrist shoulder elbow knee ankle hips
Muscle weakness numbness parasthesias (tingling) other: _____

Neuropsychological
Seizures dizziness loss of balance lack of coordination poor memory
Concussion depression anxiety bad temper easily susceptible to stress
Been treated for emotional challenges? **Yes no**
Have you ever considered or attempted suicide? **Yes no**
Any other neuropsychological issues?
_____

For practitioner use only

Observations:

_____
_____
_____

Pulses

Comments: _____
_____
_____
_____
_____
_____
_____
_____

Tongue

_____
_____

Abdominal Palpation

Comments: _____
_____
_____

Diagnosis:

_____
_____

Treatment Principle(s):

_____
_____
_____

Treatment Plan:

_____
_____
_____

Prognosis:

_____
_____