A. GENERAL INFORMATION

Date of first visit (dd/mm/yy) _____ /_____/_____

Family name _____ **First name** _____

Address _____
NO. STREET APARTMENT NO.

_____
CITY PROVINCE. COUNTRY POSTAL CODE

Telephone no. (HOME) _____ (WORK) _____

Cell phone no. _____ **E-mail** _____

Would you like to receive the Clinique Sinocare Inc. newsletter by e-mail? Yes ( ) No ( )

Date of birth (dd/mm/yy) _____ **Sex** M ( ) F ( ) **Height** _____ **Weight** _____

Marital status MARRIED ( ) LIVING WITH SOMEONE ( ) DIVORCED ( ) SEPARATED ( ) SINGLE ( )

Profession _____ **Profession of spouse** _____

Referred by (please circle the answer)**:** **A.** FRIEND; **B**. FAMILY MEMBER; **C**. COLLEAGUE; **J**. INTERNET;

I. YELLOW PAGES; ADVERTISEMENT IN **S**. CREATING FAMILY, **T**. HEALTH TIME;

E, OTHER PUBLICATION _____; **M**. OTHER _____;

O. MCGILL REPRODUCTIVE CENTRE; **P**. OVO CLINIC; **Q**. MONTREAL FERTILITY CLINIC; **R**. PROCREA.

Your doctor's name, if referred by one of above clinics _____

K. OTHER HEALTH PROFESSIONALS: NAME _____ Clinic name _____

Address/Location _____ Tel. no. _____

B. CONSENT (Please initial in space provided below.)

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Cancellation policy: I understand that all appointments have to be canceled 24 hours in advance or a $30 charge will be applied. _____

Sharing of patient file information among practitioners: I agree to allow my file be shared among practitioners in Clinique SinoCare Inc., when the clinic deems it necessary to do so. _____

Purchasing herbal products and supplements: I understand that the quoted price for an acupuncture treatment includes the prescription of herbs. The cost for a herbal medicine consultation and prescription alone is $25. _____

I understand that taking herbs and/or supplements, or purchasing any products from the clinic, is entirely optional. I understand that all alternative sources will be presented to me, and the potential benefits of herbal products will be explained to me. _____

Confidentiality: I agree not to disclose the clinic's internal operation to any third party without prior written authorization from the clinic. _____

C. CHIEF COMPLAINT & DIAGNOSIS (FERTILITY PATIENTS: PLEASE PROVIDE DETAILS IN F TO I SECTION)

D. HISTORY OF THE PRESENT COMPLAINT

E. MEDICATION AND SUPPLEMENTS PERSCRIBED

Do you take anticoagulants? YES / NO **Corticosteroids?** YES / NO

Name and address of the doctor and/or alternative health practitioner consulted

F. FEMALE FERTILITY TESTS

Date (MM/YYYY)	FSH	LH	E2	PROGESTERONE	PROLACTIN	TSH	TESTOSTERONE
1							
2							
3							
4							
5							

G. FEMALE FERTILITY TREATMENTS

No.	Clinic	Start Date (MM/YYYY)	FERTILITY TREATMENT DRUG THERAPY, IUI, IVM, IVF, ICSI, DONOR EGG OR SPERM, FROZEN CYCLE & ACUPUNCTURE	Medication & Dosage	Pregnant (Y/N)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

H. MALE FERTILITY TESTS

Date (MM/YYYY)	Sperm Count (million/ml)	Sperm Volume (ml)	Sperm Morpho-logy (%)	Sperm Motility (%) Rapid / Sluggish / Immotile/ Not forward				Lique-faction (minutes)	Other (Anti-body, etc..)
1									
2									
3									
4									
5									

I. MALE FERTILITY TREATMENTS

No.	Clinic	Start Date (MM/YYYY)	Fertility Treatment	Medication & Dosage	Result
1					
2					
3					
4					
5					

J. MEDICAL HISTORY

Have you ever suffered from the following diseases? (Please indicate in the space provided.)

Heart	_____	Kidney	_____
Lung	_____	Allergies	_____
Liver	_____	Cancer	_____
Stomach	_____	STD	_____

Hemophilia	_____	Diabetes	_____	Hypotension	_____	Hypertension	_____	AIDS	_____
Arthritis	_____	Accidents	_____	Traumatisms	_____	Eczema	_____	Urticaria	_____
Cholesterol	_____	Goitre	_____	Blindness	_____	Tuberculosis	_____	Other	_____

Do you have a metal prosthesis? NO / YES , SPECIFY _____ **Do you wear a pace-maker?** NO / YES

Surgical operations? NO / YES **Date** _____ **Nature** _____ **Hospital** _____

K. PAIN

Location _____

CONSTANT PAIN ( ) INTERMITTENT PAIN ( ) SHARP PAIN ( ) DULL PAIN ( )

Increased by: WARMTH ( ) PRESSURE ( ) EFFORT ( ) MOVING ( ) OTHER _____
Diminished by: WARMTH ( ) PRESSURE ( ) EFFORT ( ) MOVING ( ) OTHER _____

L. WORK, LIFE AND EATING HABITS

Daily habits: WORK ___ # OF HOURS/WEEK WORK-RELATED STRESS _____ FAMILY-RELATED STRESS _____

Alcohol ___ **glass / week** **Coffee** ___ **cup / day** **Recreational drugs ( )**

Tobacco ___ **cigarette / day** **Exercise** ___ **hours/week doing** _____

Exposure to any aggressive factors (noise, dust, toxic products, shift work, etc.)

Craving for foods that are SWEET ( ) SALTY ( ) SPICY ( ) ACIDIC ( ) BITTER ( ) NONE ( )

Number of meals per day _____ **Frequency** _____/hours **Are you a vegetarian?** NO / YES

Which of these ways do you prepare your food? raw ( ) fried ( ) boiled ( ) steamed ( ) sautéed ( )
What do you like the most?_____ **the least?**_____

M. FAMILY MEMBER HEALTH INFORMATION

Father Alive ( ) Deceased ( ) Age and cause _____
Mother Alive ( ) Deceased ( ) Age and cause _____
Siblings Alive ( ) Deceased ( ) Age and cause _____

In your immediate family, does anyone suffer from the following diseases?

Heart problem	_____	Paralysis	_____	Diabetes	_____	Hypertension	_____
Allergies	_____	High cholesterol	_____	Cancer	_____	Hypotension	_____

N. GENERAL PHYSICAL CONDITION

Energy level _____ **Mood** _____ **Appetite** _____

Digestion _____ **Sleep quality** _____ **Sleep duration** _____

Night urination _____ per night **Hands and/or feet cold in winter** _____ NO / YES

Libido _____ **Other** _____

O. FOR WOMEN

Age of the first menstruation: _____; **Menstrual cycle:** _____ **days;** **Cycle Day today** _____**;**

Duration of the menstruation: _____ **days;** **Date of onset of the last menstruation**_____.

Bleeding:	heavy	____	medium	____	light	____	other _____
Color:	dark red	____	bright red	____	light red	____	other _____
Density:	thick	____	medium	____	thin	____	other _____
Blood clots:	much	____	medium	____	little	____	other _____

Pain NO / YES BEFORE MENSES ____days DURING MENSES ____days AFTER MENSES ____days

Location of pain PELVIC AREA ( ) LOW BACK ( ) OVARY AREA ( ) BREAST ( ) OTHER _____

Diminished by WARMTH ( ) OR PRESSURE ( ) OR OTHER: _____

Increased by WARMTH ( ) OR PRESSURE ( ) OR OTHER: _____

_____

P.M.S. NO / YES; specific symptoms _____

Number of pregnancies: ___; **births:** ____; **miscarriages:** ___; **abortions** ____.

Presence of fertile mucus at mid-cycle NO / YES ; **on cycle day** ___ **and last for** ____ **days**;

Do you have annual PAP test? NO / YES **Are you on hormone therapy?** NO / YES

If yes, which hormone(s) and since when? _____

What contraceptive method are you using? PILL ( ) STERILIZATION ( ) CONDOM ( ) DIAPHRAGM ( )

OTHER: _____

F O R C L I N I C U S E O N L Y

P. TCM DIAGNOSIS

Tongue _____ **Coating**: _____ **Pulse** _____

Q. THERAPEUTIC PRINCIPLES

R. ACUPUNCTURE POINTS

Ear points _____

Moxibustion / Cupping _____

Electro-stimulation _____

Local massages _____

S. HERBAL PRESCRIPTIONS