

AMCH FERTILITY CLINIC REGISTRATION FORM

Name: _____ Birthdate _____

Home Address: _____ H phone _____

City, Zip: _____ W Phone: _____

Email _____ C Phone _____

Sex M F Usual Occupation _____ Employer _____

Height _____ Weight _____

Employment Status: ` School ` Homemaker ` Work ` Full time
` Part time ` Unemployed ` Disabled ` Retired

Referred by _____

Marital status _____ Number of children _____

Person to be contacted in case of emergency _____
Relationship _____ Phone _____

Family Physician _____

Insurance Provider _____

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies); include type of illness, month and year hospitalized, name of hospital, city and state.

#1: _____

#2: _____

#3: _____

Allergies: _____

Medications (Type, Dosage, Frequency) _____

Medicinal Herbs, Vitamins, Teas: _____

Do you use: ` Coffee: Amount _____ ` Cigarettes: Amount _____

` Alcohol: Amount _____ ` Other drugs: Amount _____

ADULT REGISTRATION Form page Two

Year	Tests	Year	Immunizations
_____	· Chest x-ray	_____	· Smallpox
_____	· Electrocardiogram	_____	· Tetanus
_____	· TB test	_____	· Polio
_____	· GI series	_____	· Typhoid
_____	· Kidney x-ray	_____	· Mumps, Measles
_____	· Barium Enema	_____	· Flu
_____	· Other x-rays	_____	· Other

Main complaint(s) you would like to address(Please specify how long ago the problem began) _____

Birth History: (Forceps, C-section, Prolonged labor)

Environmental exposures (list year and what type: Chemicals _____
Mold _____ Aesbestos _____ New carpet or paint _____
Other _____

Please describe your average daily diet: (include drinks and snacks)

Morning _____
Afternoon _____
Evening _____

Rate your Stress Level: (1-10 with 10 the highest) _____

What do you do to cope with stress? _____

Anything else you would like to add? _____

ADULT REGISTRATION Form page Three

If you have been bothered RECENTLY by any of these problems CHECK for yes only:

Y

- frequent or severe headaches
- back pains
- neck lumps or swelling
- loss of balance
- dizzy spells
- blackouts/fainting
- wear glasses
- blurry vision
- eyesight worsening
- see double
- see halos or lights
- eye pains or itching
- watering eyes
- hearing difficulties
- running ears
- noises in ears
- dental problems
- sore or bleeding gums
- sore tongue
- congested nose
- running nose
- sneezing spells
- head colds
- nosebleeds
- excessive sweating
- sore throat
- difficulty swallowing
- hoarse voice
- wheezing or gasping
- frequent coughing
- cough up phlegm
- cough up blood
- chest colds
- rapid or skipped heart beats
- chest pains
- shortness of breath
- swollen feet or ankles
- armpits or groin swelling
- difficulty sleeping
- motion sickness
- -hot flashes
- warm/colder than other
- motion sickness
- fever or chills
- fatigue or weariness
- always hungry
- loss of appetite

Y

- recurring indigestion
- frequent belching
- nausea
- vomiting
- pain in abdomen
- bloated abdomen
- constipation
- loose bowels
- black stools
- grey or whitish stools
- pain in rectum
- itching rectum
- blood with stools
- involuntary urination
- burning on urination
- black or bloody urine
- weak urine stream
- diff. starting urine
- constant urge to urinate
- hopeless outlook
- difficulty relaxing
- worry a lot
- night sweats
- scary dreams or thoughts
- feeling of desperation
- shy or sensitive
- dislike criticism
- angered easily
- annoyed by little things
 - family problems
 - problems at work
 - sexual difficulties
- change of sexual energy
- considered suicide
- loss or gain in weight
- frequent crying
- lonely or depressed
- loss of memory
- lack of concentration
- --diff. making decisions
- nail biting
- nervous with strangers
- nervousness or anxiety
- frequent urination
- earaches
- bruise easily
- itching or burning skin

Y

- aching muscles or joints
- swollen joints
- back or shoulder pains
- weakness in arms or legs
- painful feet
- trembling
- numbness
- leg cramps
- skin problems
- scalp problems

MEN ONLY

- - burning or discharge
- -swelling on testicles
- - painful testicles
- - impotency

WOMEN ONLY

- -endometriosis
- -pain on intercourse
- -swelling of breasts
- -nipple discharge
- -breast lumps
- -clots during menses
- -postcoital bleeding
- -painful periods
- -missed periods
- -menstrual problems
- -bleeding between periods
- -heavy bleeding
- -ovarian cysts
- -vaginal discharge
- -genital irritation
- ____Period between menses
- ____Age of first menses
- ____#of pregnancies
- ____#of births
- ____#of miscarriages
- ____#of premature birth
- ____#of caesarean
- ____#of abortions
- ____Menopause: Age
- ____Date of last pap test
- ____Do you practice birth control?
- ____What type?
- ____For how long?

ADULT REGISTRATION Form Page Four

What are you most sensitive to (eg. noise, odors, light, pain)? _____

Describe an ideal day in terms of weather and temperature: _____

What are your fears? _____

Do you have any hobbies? _____

(Women only) What symptoms do you experience premenstrually? _____

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: _____

How is your energy? Is there any particular time of day when it is lower or higher? _____

What environment do you feel most comfortable in? (ie desert, mountains, ocean, city) _____

How is your sexual interest/drive? _____

What do you most like to eat or crave? _____

What is your favorite color? _____

What foods do you most dislike? _____

How is your thirst? _____

What temperature do you like fluids? _____

Are there any foods that you are sensitive to or allergic to? _____
