

# Women's Fertility History

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*Eileen Zhuo, L. Ac., M.S.*

**Acupuncture & Chinese Medicine Center**

7250 France Ave South Suite 308 Edina, MN. 55435 • Phone: 952-820-0877

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

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Age at, which menses began? \_\_\_\_\_

Are your periods painful?  Yes  No

How many days do you normally bleed? \_\_\_\_\_

How heavy is the bleeding?

Light  Medium  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

Face break out?  Yes  No

Breast tenderness?  Yes  No

Bleed or spot between periods?  Yes  No

Loose stool?  Yes  No

lower back pain?  Yes  No

Other \_\_\_\_\_

How many days are between periods? \_\_\_\_\_

Date of your last menstrual period? \_\_\_\_\_

How many pregnancies have you had?

Number \_\_\_\_\_ Year \_\_\_\_\_

How many children have you had?

Number \_\_\_\_\_ Year \_\_\_\_\_

How many abortions have you had?

Number \_\_\_\_\_ Year \_\_\_\_\_

How many miscarriages have you had?

Number \_\_\_\_\_ Year \_\_\_\_\_

How many times has a D&C been performed?

Number \_\_\_\_\_ Year \_\_\_\_\_

Have you ever had an abnormal pap smear?  Yes  No

Have you ever had a cervical biopsy?  Yes  No

Have you ever had an operation?  Yes  No

Have you ever had venereal disease?  Yes  No

Do you get yeast infections regularly?  Yes  No

Have you ever been diagnosed with a chlamydial infection?  
 Yes  No

Do you have a chronic vaginal discharge?  Yes  No

Do you have sores on your genitalia?  Yes  No

Have you ever had pelvic inflammatory disease (PID)?  
 Yes  No

Were you treated for it?  Yes  No

When/How \_\_\_\_\_

Date of your last Pap smear? \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids or polyps?  
 Yes  No, Year \_\_\_\_\_

Have you ever been diagnosed with endometriosis?  
 Yes  No, Year \_\_\_\_\_

Have you ever been diagnosed with pelvic adhesions?  
 Yes  No, Year \_\_\_\_\_

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

Have you taken any medications for gynecological conditions?  
other than contraceptives?  Yes  No (list below)

<b><i>Medication</i></b>	<b><i>Reason</i></b>	<b><i>How Long</i></b>
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Have your cycles changed since they began  Yes  No

How? (Explain)

Do you ovulate on your own?  Yes  No

On what day of your cycle? \_\_\_\_\_

Do your breast get tender  at ovulation or  during ovulation?

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Date of Birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Have you had fertility treatments  Yes  No, If yes,

<u>When</u>	<u>What types</u>	<u>Where &amp; By Whom</u>
_____		
_____		
_____		

Do you exercise regularly?  Yes  No

Do you have excessive facial hair?  Yes  No

Do you have excessive loss of head hair?  Yes  No

Have you notice discharge from your nipples?  Yes  No

Have you been exposed to any known environmental toxins or hormones?  Yes  No

Have you taken medication to help you ovulate?  
 Yes  No, When? \_\_\_\_\_

Are you presently taking steroids?  Yes  No

Have your fallopian tubes been evaluated medically?  
 Yes  No

Do you have a future IUI or IVF procedure scheduled?  Yes  No

What were the results? \_\_\_\_\_

Last day of Birth Control Pill \_\_\_\_\_

Have you had any hormone laboratory tests performed?  
 Yes  No

First day of Lupon \_\_\_\_\_

What were the results? \_\_\_\_\_

First day of Stimulation Medication \_\_\_\_\_

Has your partner had fertility workup?  Yes  No

Day of IUI \_\_\_\_\_

What were the results? \_\_\_\_\_

Day of retrieval \_\_\_\_\_

Is your partner supportive of your wish to conceive?  
 Yes  No

Day of transfer \_\_\_\_\_

Have you had or taken the following

**Do you have any other comments?**

<u>When</u>	<u>How Long</u>
_____	
_____	
_____	

Oral contraceptive \_\_\_\_\_

IUD \_\_\_\_\_

DepoProvera \_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

Have you had a diagnosis relating to infertility?  Yes  No

What was the diagnosis \_\_\_\_\_

How is your sexual energy?  
 Low  Normal  High

Do you douche regularly?  Yes  No

Do you use vaginal lubricants?  Yes  No

Do you have a stressful occupation?  Yes  No