

Women's Fertility History

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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: _____

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)

<u>Medication</u>	<u>Reason</u>	<u>How Long</u>
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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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Have you had fertility treatments Yes No, If yes,

When What types Where & By Whom

Have you taken medication to help you ovulate?

Yes No, When? _____

Have your fallopian tubes been evaluated medically?

Yes No

What were the results? _____

Have you had any hormone laboratory tests performed?

Yes No

What were the results? _____

Has your partner had fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive?

Yes No

Have you had or taken the following

When How Long

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

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

Are you presently taking steroids? Yes No

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

Last day of Birth Control Pill _____

First day of Lupon _____

First day of Stimulation Medication _____

Day of IUI _____

Day of retrieval _____

Day of transfer _____

Do you have any other comments?

Notes (office use only)

