Alpenglow Acupuncture, LLC - Women's Fertility History

Name (Last, First, Middle)	Date

Age at which menses began_____

Are your periods painful? □ Yes □ No

How many days does the pain last? _____

How many days do you normally bleed?__ ____

How heavy is the bleeding? □ Light □ Normal □ 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

Does your face break out before or during your period? □ Yes □ No

Do your breasts become tender premenstrually? □ Yes □ No

Do you bleed or spot between periods? □ Yes □ No

Are your menstrual cycles spaced irregularly? □ Yes □ No

How many days are there from on period to the next? _____

Date of last menstrual period_____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been preformed?	_____	_____

Have you ever had an abnormal pap smear? □ Yes □ No

Have you ever had a cervical biopsy, operation, cauterization or conization? □Yes □ No

Have you ever had venereal disease? □ Yes □ No

Do you get yeast infections regularly? □ Yes □ No

Have you ever been diagnosed with Chlamydia infection? □ Yes □ No

Do you have chronic vaginal discharge? □ Yes □ No

Do you have any sores on your genitalia? □ Yes □ No

Have you ever had pelvic inflammatory disease? □ Yes □ No

Were you treated for it? □ Yes □ No

How_____

_____

Date of last Pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps?□Yes □ No

Have you ever been diagnosed with endometriosis? □ Yes □ No

Have you been diagnosed with pelvic adhesions? □ Yes □ No

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

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? □ Yes □ No

How? _____

Do you ovulate on your own? □ Yes □ No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? □ Yes □ No

Do you get premenstrual low back pain? □ Yes □ No

Do your bowel movements become loose at the beginning of your period? □Yes □ No

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Name (Last, First, Middle)	Date

Have you ever had fertility treatments? □ Yes □ No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When _____How long? _____

Have your fallopian tubes been evaluated medically? Yes No

Have you had any tubal operations? □ Yes □ No

Have you had any hormone laboratory tests performed? □ Yes □ No

What were the results? _____

_____

Do you have a single partner with whom you have been trying to conceive?

□ Yes □ No

How long have you been married or living together? _____

Has he had a fertility work up? □ Yes □ No

What were the results? _____

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

Have you taken oral contraceptives? □ Yes □ No

When_____ How long? _____

Have you had an IUD? □ Yes □ No

When_____ How long? _____

COMMENTS/NOTES:

Have you ever taken Depo-Provera? □ Yes □ No

When_____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? □ Yes □ No

What was it? _____

How is you sexual energy? □ Low □ Normal □ High

Do you douche regularly? □ Yes □ No

With what? _____

Do you use vaginal lubricants? □ Yes □ No

Do you have mucous production? □ Yes □ No

How is your mucous? □ thick/clumpy □ stringy □ thin □ varies

Are you more than 20% over your ideal body weight? □ Yes □ No

Are you more than 20% below your ideal body weight? □ 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 excessively oily skin? □ Yes □ No

Have you experienced excessive loss of head hair? □ Yes □ No

Have you noticed discharge from your nipples? □ Yes □ No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? □ Yes □ No

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

Are you presently taking steroids? □ Yes □ No

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