Acupuncture and Alternative Medicine Clinic
250 W. Lancaster Ave
Suite 150
Paoli, Pa 19301

Women's Fertility History

Name:	Date:

1. **Menstrual Cycle**
   - How many days between your cycles? _____
   - How long does your period last?_____
   - Date of last menstrual period? _____
   - Are your periods regular? Yes/No (if No please explain)_____
     _____
   - How heavy is the bleeding? (Light Normal Heavy)
   - What color is the blood?(normal red light red dark red brown black)
   - Is there clotting? Yes (small or big) or No
   - Age at which menses began_____
   - Have cycles changed since they began?
   - If you ovulate, what day of the cycle?

2. **Pre-Menstrual Issues**

Check if you have any of the following:

- ☐ PMS Symptoms
- ☐ Sore/Tender Breasts
- ☐ Acne Breakouts
- ☐ Irritable, Depressed
- ☐ Low back pain (circle one) before during after cycle
- ☐ Loose Stools (circle one) before during after cycle
- ☐ Headaches before during after cycle
- ☐ Other_____

3. **Gynecology History**
   - Have you ever had any of the following procedures: (please circle one)

Abnormal Pap Smear
Cervical Biopsy
Cervical Operation
Cauterization
Corization

- When?_____
- Date of last Pap Smear?_____

- Other gynecological procedures?_____
- Gynecology Surgeries?_____

- Have you ever had any of the following?

□ Yeast infections regularly
□ Chronic Vaginal Discharge
□ Painful Intercourse

- Have you ever been diagnosed with any of the following?

□ Endometriosis
□ HPV (Human Papiloma Virus)
□ Venereal Disease
□ Chlamydia
□ Genital Herpes
□ Uterine Fibroids or Polyps
□ Pelvic Adhesions
□ Pelvic Inflammatory Disease

- If yes to any of the above, when were you treated?_____
- How were you treated?_____

	How Many	Year
Pregnancy	_____	_____
Children	_____	_____
Abortions	_____	_____
Miscarriages	_____	_____

Have you ever taken oral contraceptives?
Yes or No

When? _____ How long? _____

□ Do you use an IUD? **Yes or No**

4. Fertility Treatment History

How long have you been trying to conceive?_____
Do you have a diagnosis related to infertility?_____
Have you had fertility treatments? Please explain when and by whom?
_____
_____
_____
_____
_____
_____

Have you had a faalopian tube evaluation? **Yes** (normal or abnormal) **No**

Have you had other functional tests?_____
What were the results?_____
What hormonal laboratory tests were performed?_____
What were the results?_____
Please list any and all medications you are currently taking:

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

5. Lifestyle

How is your sexual energy (please circle) **low** **normal** **high**

□ Do you douche?
□ Do you use vaginal lubricants?
□ Do you have a stressful occupation?
□ What do you do and how often?_____
□ Do you have excessive facial hair?_____
□ Excessive loss of head hair?
□ Discharge from nipples?

What is your height_____ weight_____
□ Was your mother exposed to DES (diethylstilbestrol) when she pregnant?
□ Have you been exposed to any known environmental toxins or hormones?
_____