



Acupuncture and Alternative Medicine Clinic
915 Montgomery Ave
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Women's Fertility History

Name:	Date:
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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?
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