Women Fertility History Form

TRAN ACUPUNCTURE

Date

First Name | MI | Last Name

Date last menses (period) began:

At what age did you have your first menstruation?

Is your menstrual cycle □ Regular □ Irregular

Do you ovulate on your own? □ No □ Yes

How long is your typical cycle? (i.e. 24-30 days): Days

Do you experience pain around ovulation? □ No □ Yes

How many days do you bleed in total? Days

Do your breasts get tender around ovulation? □ No □ Yes

Check what describes your flow and the consistency and color of the blood:

Flow	Consistency	Color	
□ Light	□ Watery	□ Dark red	□ Brown
□ Moderate	□ Moderate	□ Red	□ Purple
□ Heavy	□ Thick	□ Brownish Red	□ Pink

Do you chart your cycle? □ No □ BBT □ Ovulation sticks □ Saliva □ Other

Do you notice stretchy, slippery, clear, egg white-like mucous around ovulation? □ No □ Yes

At which point in the cycle does your blood contain clots? □ Never □ Start □ Midpoint □ End

Do you experience menstrual pain? □ No □ Before □ During □ After □ Intermittent

Is the pain: □ Stabbing □ Cramping □ Dull Ache □ Heavy □ On/Off
What relieves the pain?

Do you experience any of these PMS symptoms?

□ Breast tenderness □ Bloating □ Fatigue
□ Headaches □ Night sweats □ Acne
□ Sleep disturbances □ Nausea □ Moodiness
□ Cramps □ Bowel changes □ Other:

Have you had any miscarriages or stillborn births? □ No □ Yes

If yes, how many and number of weeks pregnant:

How many times have you been pregnant?

How many times have you given birth?
Age(s) of child(ren):

How many times have you had a D&C performed?

How many abortions have you had? In what year(s)?

□ Vaginal Delivery □ C-Section □ Premature _____ weeks

Have you had any tubal operations? □ No □ Yes

Other problems during pregnancies:

Which forms of chemical contraception have you used, for how long, and when did you stop? (time used/approx. date ended)

□ Oral _____ / _____ □ Depo-Provera _____ / _____
□ IUD _____ / _____ □ Other _____ / _____

Have you taken medication to help you ovulate? □ No □ Yes

What kind? For how many cycles?

Have you had your uterine/fallopian tubes evaluated medically? □ No □ Yes

If yes, what were the results?

Women Fertility History Form (continued)

Patient Name: _____

Do you have a partner with whom you have been trying to conceive? □ No □ Yes	How long have you been trying to conceive?
How long have you been married or living together?	Is he/she supportive of your wish to conceive? □ No □ Yes
Have either of you had a western medical diagnosis relating to fertility? □ No □ Yes If yes, when?	
If yes, please describe the diagnosis for her:	For him:

Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) □ No □ Yes

Clinic	Month / Year	Type of treatment	Results

Are you using donor sperm? □ No □ Yes

How would you rate your level of sexual desire? □ Low □ Average □ High	Changes? □ Decreased □ Increased □ Unchanged
What is your orgasm frequency / intensity? □ Low □ Average □ High	Changes? □ Decreased □ Increased □ Unchanged

Do you use vaginal lubricants? □ No □ Yes	Have you been exposed to or received chemotherapy/radiation? □ No □ Yes If yes, when?

Have you ever experienced an emotional, spiritual, or physical incident from which you feel you have never recovered your previous level of health? Please discuss briefly:

Have you had any hormone lab test performed? Please indicate the results:

FSH	□ High	□ Normal	□ Low	Prolactin	□ High	□ Normal	□ Low
Estrogen, E2	□ High	□ Normal	□ Low	Thyroid	□ High	□ Normal	□ Low
Progesterone	□ High	□ Normal	□ Low	Vitamin D	□ High	□ Normal	□ Low
Testosterone	□ High	□ Normal	□ Low	DHEA	□ High	□ Normal	□ Low

Have you ever been diagnosed with:			Gynecological history:		
Pelvic Inflammatory Disease	□ No	□ Yes	Date of your last pap smear (mm/dd/yy) / /		
Uterine fibroids	□ No	□ Yes	Have you ever had an abnormal pap smear?	□ No	□ Yes
Polyps	□ No	□ Yes	Have you ever had Cervical biopsy or operation?	□ No	□ Yes
Pelvic adhesions	□ No	□ Yes	Do you get yeast infections frequently? > 4x/year	□ No	□ Yes
Prolapsed uterus	□ No	□ Yes	Do you get bladder infections or UTIs frequently?	□ No	□ Yes
Endometriosis	□ No	□ Yes	Do you experience vaginal discharge?	□ No	□ Yes
PCOS (polycystic ovarian syndrome)	□ No	□ Yes	If yes, please describe color, consistency, and odor:		
Unique shape of uterus	□ No	□ Yes	□ White □ Yellow □ Green □ Pink □ Red		
STD	□ No	□ Yes	□ Thin □ Thick □ Sticky		
If yes, please list STDs:			Odor:		