EAST WIND ACUPUNCTURE FERTILITY HISTORY

Please bring pertinent medical records and basal body temperature charts if applicable.

Name: Last, First:_____Date:_____

-Age at which menses began:_____ -Are your periods painful? Y/N
-How many days does your 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? Y/N
-Do you have premenstrual tension? Y / N
-Does your face break out before or during your period? Y/ N
-Do your breasts become tender premenstrually? Y/N -Do you bleed or spot between periods? Y/N
-Are your menstrual cycles spaced irregularly? Y/N
-How many days are there from one 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 performed?	_____	_____

-Have you ever had an abnormal pap smear? Y/N
-Have you ever had a cervical biopsy operation, cauterization or conization? Y/N
-Have you ever had a venereal disease Y/N -Do you get yeast infections regularly? Y/N
-Do you have any sores on your genitalia? Y/N
-Have you ever been diagnosed with a chlamydial infection? Y/N
-Do you have chronic vaginal Discharge? Y/N -Have you ever had pelvic inflammatory disease? Y/N

-Were did treated for it Y /N How ?_____
-Date of last Pap smear: _____ -Have you been diagnosed with pelvic adhesions? Y/N
-Have you ever been diagnosed with uterine fibroids or polyps? Y/N -Size (if known)_____
-Have you ever been diagnosed with endometriosis? Y/N
-Have you been diagnosed with any pelvic abnormalities? Y/N
-Have you taken any medications for gynecological conditions other than contraceptives?

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

-Have your cycles changed since they began? Y/N, for how long? _____
-Do you ovulate on your own? Y/N - On what day of your cycle? _____
-Do your breasts get tender at/during ovulation? Y/N
-Do you get premenstrual low back pain? Y/N

-Do your bowel movements become loose at the beginning of your period? Y/N
-Have you had fertility treatments? Y/N -If yes, when,where, by who?_____
_____
-What types? _____
-Have you taken medication to help you ovulate? Y/N When: _____
-How long:_____
-Have your fallopian tubes been evaluated medically? Y/N -What were the results?_____
_____
-Have you had any tubal operations? Y/N -Have you had any hormone laboratory tests performed? Y/N
-What were the results?_____
-Do you have a single partner with whom you have been trying to conceive? Y/N
-How long have you been together? _____ -Has he had a fertility workup? Y/N
-What were the results?_____
-Is your partner supportive of your wish to conceive? Y/N -Have you taken oral contraceptives? Y/N
-When _____ How Long? _____
-Have you had an IUD?Y/N When_____ How long? _____
-Have you ever taken Depo-Provera? Y/N When_____ How long? _____
-How long have you been trying to conceive?_____
-Have you had a diagnosis related to infertility? Y/N -What type?_____
_____

-How is your sexual energy? Low/Normal/High -Do you douche regularly Y/N
-With what? _____

-Do you use vaginal lubricants? Y/N -Are you more than 20% over your ideal body weight? Y/N
-Do you have a stressful occupation? Y/N -Do you exercise regularly? Y/N
-Do you have excessive facial hair? Y/N -Do you have excessively oily skin? Y/N
-Have you experienced excessive loss of head hair? Y/N -Are you presently taking steroids? Y/N
-Have you noticed discharge from your nipples? Y/
-Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Y/N
-Have you been exposed to any known environmental toxins or hormones? Y/N

-Is there any other information we should know about you, your cycles, fertility or other health problems you are concerned about?