EAST WIND ACUPUNCTURE FERTILITY HISTORY

Name:_____ Date:_____

Age at which menses began:_____ Are your periods painful? ◯Yes ◯No

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? ◯Yes ◯No

Do you have premenstrual tension? ◯Yes ◯No

Does your face breakout 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? Y◯Yes ◯No

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?	_____	_____

Date of last pap smear:_____

Have you ever had an abnormal pap smear? ◯Yes ◯No What were the results? _____

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

Have you ever had a venereal disease? ◯Yes ◯No

Do you get yeast infections regularly? ◯Yes ◯No

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

Have you ever been diagnosed with a chlamydial infection? v

Do you have chronic vaginal discharge? ◯Yes ◯No

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

Were you treated for it? ◯Yes ◯No How?_____

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

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 any pelvic abnormalities? ◯Yes ◯No

Have you taken any medications for gynecological conditions other than contraceptives? ◯Yes ◯No

What were they? _____

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

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

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

Have you had fertility treatments in the past? ◯Yes ◯No

If yes, when, where, by who? _____

What types of treatments? _____

Have you taken medication to help you ovulate? ◯Yes ◯No When?_____

How long did you take them?_____

Have your fallopian tubes been evaluated medically? ◯Yes ◯No

What were the results? _____

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? _____

How long have you been together? _____ Has he had a fertility workup? ◯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? _____

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

When?_____

How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis related to infertility? ◯Yes ◯No

What type?_____

How is your sexual energy? L◯ow ◯Normal ◯High

Do you douche regularly? ◯Yes ◯No With what? _____

Do you use vaginal lubricants? ◯Yes ◯No

Are you more than 20% over 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

Are you presently taking steroids? ◯Yes ◯No What Kind: _____

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

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