Mountain View Acupuncture
www.mountainviewacupuncture.com
541-388-0675

Initials: ___________

Women's Fertility History

Patient Name: ____ **Date:** ______________

1. **Menstrual cycle**
   How long does your period last? ______________
   Date of last menstrual period? ______________
   How many days between cycles? ______________
   Are your periods irregular? Please explain ______________________________________
   ____
   How many days are from one period to the next? ______________
   How heavy is the bleeding? light normal heavy
   What color is the blood? normal red light red dark red purple brown black
   Is there clotting? yes 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 symptoms of 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 (circle one) before during after cycle

   Other ____

3. **Gynecology History**
   Have you ever had any of the following procedures: (please circle)
   Abnormal Pap smear, cervical biopsy, cervical operation, cauterization, conization?
   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	__________	__________
D & C's	__________	__________

Have you ever taken oral contraceptives? When? __________ How long? __________

- ☐ Do you use an IUD?

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? (use another sheet if necessary)

Have you ever had a fallopian tube evaluation? yes 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?
- ☐ Do you exercise regularly?
  - 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? ______________ and weight? ______________

- ☐ Was your mother exposed to DES (diethylstilbestrol) when she was pregnant?
- ☐ Have you ever been exposed to any known environmental toxins or hormones?

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