Mountain View Acupuncture, LLC
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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?

What color is the blood?

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 (choose one)

- ☐ Before Cycle
- ☐ During Cycle
- ☐ After Cycle

Loose Stools (Choose one)

- ☐ Before Cycle
- ☐ During Cycle
- ☐ After Cycle

Headaches

- ☐ Before Cycle
- ☐ During Cycle
- ☐ After Cycle

Other:

3. Gynecology History

Have you ever had any of the following procedures: (check all that apply)

- ☐ Abnormal Pap Smear
- ☐ Cervical Biopsy
- ☐ Cervical Operation
- ☐ Cauterization
- ☐ Conization

Please list the dates of each of the previously selected procedures:

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 and how were you treated?

Pregnancy: How many and What year(s):

Children: How many and What year(s):

Abortions: How many and What year(s):

Miscarriages: How many and What year(s):

D & C's: How many and What year(s):

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

Do you use an IUD?

- ◯ Yes
- ◯ 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 ever had a fallopian tube evaluation?

- ◯ Yes
- ◯ No

Have you had other functional tests?

What were the results of the other tests?

What hormonal laboratory tests were performed?

What were the results?

Please list all medications you are currently taking: Medication, Reason and for how long:

5. Lifestyle

How is your sexual energy

- [ ] Low
- [ ] Normal
- [ ] High

Do you douch?

- [ ] Yes

Do you use vaginal lubricants?

- ◯ Yes

Do you have a stressful occupation?

- [ ] Yes

Do you exercise regularly? If so, what do you do and how often?

Do you have excessive facial hair?

- [ ] Yes

Excessive loss of head hair?

- [ ] Yes

Discharge from nipples

- [ ] Yes

What is your height?

What is your weight?

Was your mother exposed to DES (diethylstilbestrol) when she was pregnant?

Have you ever been exposed to any known environmental toxins or hormones?