HEALTHY LIVING ACUPUNCTURE AND WELLNESS

WOMEN'S FERTILITY HISTORY

 CONFIDENTIAL

55 STAFFORD STREET. PLYMOUTH, WISCONSIN 53073

Name:	Date:

Age when menses began: ______

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

If yes, how? ______

Are your periods painful? ◯ Yes ◯ No

If yes, how many days does the pain last? ______

How many days do you normally bleed? ______

How heavy is the bleeding?

	1	2	3	4	5	6	7	8	9	10	11	12
Heavy												
Normal												
Light												

Day

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 break out 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 cycle spaced irregularly? ◯ Yes ◯ No

Date last mentrual cycle began ______

Have you ever had an abnormal pap smear? ◯ Yes ◯ No

If yes, date? ______

	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 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

Have you ever been diagnosed with chlamydia? ◯ Yes ◯ No

Do you have chronic vaginal discharge? ◯ Yes ◯ No

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

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

If yes, how were you treated for it? ______

______

Date of last pap smear ______

Have you ever been diagnosed with uterine fibroids or polyps? ◯ Yes ◯ No

Have you been diagnosed with endometriosis? ◯ Yes ◯ No

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

Have you ever been diagnosed with any pelvic abnormalities? ◯ Yes ◯ No

Have you ever taken oral contracepives? ◯ Yes ◯ No

When? ______ How long? ______

Have you ever taken DepoProvera? ◯ Yes ◯ No

When? ______ How long? ______

other than contraceptives? ◯ Yes ◯ No

Medication	Reason	How Long

2024 Healthy Living Acupuncture

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Name:	Date:

How long have you been trying to conceive? ____________

Have you had a diagnosis relating to fertility? ◯ Yes ◯ No

If yes, what was it? ____________

Have you had fertility treatments? ◯ Yes ◯ No

If yes, when? ____________
Where? ____________
By whom? ____________
What types? ____________

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

If yes, what? ____________
When? ____________
How long? ____________

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

If yes, what were the results? ____________

Have you had any tubal operations? ◯ Yes ◯ No

Have you had any hormone lab tests perfomed? ◯ Yes ◯ No

If yes, what were the results? ____________

____

____

Have you been exposed to any known environmental toxins or hormones? ◯ Yes ◯ No

Are you currently taking steroids? ◯ Yes ◯ No

How is your sexual energy? ◯ Low ◯ Normal ◯ High

Do you have a single partner with whom you have been trying to conceive? ◯ Yes ◯ No

If yes, how long have you been together? ____________

Has he had a fertility workup? ◯ Yes ◯ No

If yes, what were the results? ____________

Is your partner supportive of your wish to conceive? ◯ Yes ◯ No

Do you douche regularly? ◯ Yes ◯ No

If yes, with what? ____________

Do you use vaginal lubricants? ◯ Yes ◯ No

Are you more than 20% over your ideal body weight? ◯ Yes ◯ No

Are you more than 20% under your ideal body weight? ◯ Yes ◯ No

Do you have a stressful occupation? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you drink coffee, tea or sodas? ◯ Yes ◯ No

If yes, how much? ____________

Do you smoke? ◯ 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

Have you noticed discharge from your nipples? ◯ Yes ◯ No

Notes: ____________

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