Patient Health & Fertility History

General Information

Date: ___/___/___
Name _____ DOB ___/___/___ Age _____
Significant Other Name _____ DOB ___/___/___ Age _____

Gender _____ Height _____ Weight _____ Marital Status _____ Occupation _____
Number of years together _____

Home Phone _____ Work Phone _____ Cell Phone _____
Best phone # for weekday appointments? _____ Weeknight? _____ Weekend? _____
Email _____ Your time zone is: _____
Mailing address: _____

Primary Care Doctor _____ Gynecologist _____
Have you seen a fertility specialist? _____ When? _____
Fertility Specialist MD _____ Clinic Name _____

Describe any diagnosis or reasons given for infertility: _____
_____
_____

How long have you been trying to conceive? _____
Is your partner supportive of your desire to have a child? _____
Reason(s) you are coming to see us: _____
_____

Pregnancy & Contraceptive History

FEMALE HISTORY *(Note: If patient is a male, please still fill this out for your partner.)*

Times Pregnant _____
Term Births _____ Year/Age _____ Dates _____
Premature Births _____ Year/Age _____
Miscarriages _____ Year/Age _____ Contraceptive Type _____
Elective Abortion _____ Year/Age _____ Dates _____

Contraceptive Type _____

MALE HISTORY *(Note: If patient is a female, please still fill this out for your partner.)*
Times helped a woman achieve pregnancy: _____ Year/Your age _____

Operations & Hospitalizations

1. Year _____ Diagnosis/Operation _____
2. Year _____ Diagnosis/Operation _____
3. Year _____ Diagnosis/Operation _____
4. Have you ever had any blood transfusions? _____ If so, reason: _____

Medications & Allergies

List all current prescription medications and over-the-counter drugs:

1. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
2. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
3. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
4. Drug _____ Dose/Frequency _____ Duration _____ Reason _____

List any other prescription medications and over-the-counter drugs used during the past year:

1. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
2. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
3. Drug _____ Dose/Frequency _____ Duration _____ Reason _____
4. Drug _____ Dose/Frequency _____ Duration _____ Reason _____

List any current herbal supplements, vitamins or minerals:

1. Substance _____ Dose/Frequency _____ Duration _____ Reason _____
2. Substance _____ Dose/Frequency _____ Duration _____ Reason _____
3. Substance _____ Dose/Frequency _____ Duration _____ Reason _____
4. Substance _____ Dose/Frequency _____ Duration _____ Reason _____
5. Substance _____ Dose/Frequency _____ Duration _____ Reason _____
6. Substance _____ Dose/Frequency _____ Duration _____ Reason _____

List any allergies and explanation of reaction:

1. Drug or substance _____ When _____ Reaction _____
2. Drug or substance _____ When _____ Reaction _____
3. Drug or substance _____ When _____ Reaction _____

Women Only

Age at which periods began _____ Dates of last two periods (1st day) ___/___/___ and ___/___/___
How many days does your bleeding usually last? _____
How heavy is the bleeding? ☐ Scanty ☐ Light ☐ Normal ☐ Heavy
What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Black ☐ Brown
What is the consistency of the blood? ☐ Watery ☐ Thin ☐ Medium ☐ Thick ☐ Pasty ☐ Clots
Any further explanation of bleeding? _____
What day of your cycle do you believe you ovulate? _____
Explain symptoms, if any, you experience around ovulation: _____

Do you experience cramps/pelvic pain: ☐ During menses ☐Before ☐After ☐Midcycle ☐During sex
Cramps last _____ days. They are: ☐ Mild ☐ Moderate ☐ Severe (so bad that you stay home)
Description of cramps: ☐ Burning ☐ Dull ☐ Aching ☐ Stabbing ☐ Bearing down
☐ Intermittent ☐ Consistent ☐ Other _____
Does a heating pad help your cramps? ☐ yes ☐ no

Is length the same from one period to the next? ☐ yes ☐ no How many days _____
Is your period sometimes late? ☐ yes ☐ no Early? ☐ yes ☐ no Skip? ☐ yes ☐ no
Do you spot or bleed between periods? ☐ yes ☐ no When _____

Have your cycles changed? ☐ yes ☐ no Explanation _____
_____
Do you have chronic vaginal discharge? ☐ yes ☐ no Explanation _____
Do you usually have orgasms with intercourse? ☐ yes ☐ no Explanation _____
Do you douche? ☐ yes ☐ no Explanation _____
Date of last pap smear? ___/___/___ Normal? ☐ yes ☐ no Explanation _____

Which of the following PMS type symptoms do you experience either just before or during your periods?

☐ Bloating	☐ Breast tenderness	☐ Cravings	☐ Sadness	☐ Vaginal dryness
☐ Headaches	☐ Acne	☐ Loose stools	☐ Frustration/anger	☐ Low back pain
☐ Nausea	☐ Poor appetite	☐ Constipation	☐ Mood swings	☐ Other _____
☐ Dizziness	☐ Light-headed	☐ Vaginal itch		

Have you been diagnosed with any of the following?

☐ Uterine fibroids	☐ Chronic yeast infections	☐ PID	☐ Cervicitis
☐ Fibrocystic breasts	☐ Ovarian cysts	☐ Endometriosis	☐ Recurrent vaginitis
☐ Abnormal uterus shape	☐ PCOS	☐ Pelvic adhesions	☐ Other _____

Men Only

Have you had a prostate check-up? ☐ yes ☐ no Results _____
Have you ever had a trauma to the testicular area? ☐ yes ☐ no Explanation _____
Which of the following do you experience or have you received a diagnosis?

☐ Delayed stream	☐ Increased libido	☐ Testicular pain	☐ Rectal dysfunction
☐ Dribbling	☐ Decreased libido	☐ Groin pain	☐ Varicocele
☐ Retention of urine	☐ Impotence	☐ Prostate problems	☐ Other _____
☐ Premature ejaculation	☐ Testicular swelling	☐ Nocturnal emission without dreams	
☐ Low sperm count	☐ Low sperm motility	☐ Poor sperm morphology/form	
☐ Hormonal issue	☐ Thick seminal fluid	☐ Testicular failure to descend when born	

Current/Past Diseases or Disorders

Please check off any of the diseases or disorders you have had in the past or currently have:

☐ Chlamydia	☐ Hypertension	☐ Ulcers	☐ Toxic chemical exposure _____
☐ Genital herpes	☐ High cholesterol	☐ Epilepsy/seizures	☐ Kidney disorder _____
☐ Gonorrhea	☐ Low BP	☐ Stroke	☐ Autoimmune disease _____
☐ Syphilis	☐ Colitis/enteritis	☐ Diabetes	☐ Cancer, type _____
☐ Genital warts	☐ Appendicitis	☐ Hepatitis _____	☐ Psychiatric _____
☐ Trichomonas	☐ Asthma	☐ Anemia	☐ Thyroid disorder _____
☐ Mumps	☐ Rheumatic fever	☐ Nipple discharge	☐ Liver disorder _____
☐ Rubella	☐ Scarlet fever	☐ Chronic headache	☐ Heart/valve issue _____
☐ Chicken pox	☐ Mononucleosis	☐ Migraines	☐ Genetic diseases _____
☐ Genital sores	☐ Anorexia/Bulima	☐ Excessive oily skin	☐ Recent weight loss _____ lbs
☐ Tuberculosis	☐ Clinical depression	☐ Excess facial hair	☐ Recent weight gain _____ lbs
☐ HIV	☐ Bi Polar	☐ Hot flushes	☐ Other STD _____

☐ Other diagnosed disease/disorder _____

Fertility Therapy

Have you been treated for infertility previously with acupuncture, herbal medicine or nutrition? ☐yes ☐no
Explain any positive or negative results or changes you noticed:_____
_____

Have you/partner been treated for infertility by a gynecologist or physician? ☐ yes ☐ no
Are you currently undergoing treatment? ☐ yes ☐ no Explanation _____
Have you/partner undergone the following? ☐ Clomid ☐ Fertility shots _____
☐ Artificial Insemination (IUI) ☐ In Vitro Fertilization (IVF) ☐ Other _____
If so, how many cycles? _____
What were the results? _____
Explain any significant lab work, hormone levels, exams, ultrasounds and their findings: _____
_____
_____
What drugs have you taken for infertility? _____

Explain any changes you have made in your life to increase the chance of conception (dietary, relaxation techniques, etc.): _____
_____
_____

Other History

Rate your stress level from [0] being no stress, [10] excessive almost unbearable stress: _____
What are the most significant causes of stress in your life? (work, traffic, etc.): _____
_____
Are you doing anything to help decrease your stress? (yoga, exercise, less work) _____
_____
Do you smoke? ☐ yes ☐ no If yes, how many cigarettes per day during the week? ____ Weekend? ____
How many alcoholic drinks/week? _____ What type of alcohol? _____
How many cups of coffee/day? _____ How many cups & type of tea? _____
How many hours of sleep/day do you get during the weekday? _____ Weekend? _____
How often do you use NSAIDs (aspirin, Tylenol, Advil, etc.)? _____
Do you feel well rested when you wake? ☐ yes ☐ no
Do you frequently use hot tubs? ☐ yes ☐ no
Do you frequently use an electric blanket? ☐ yes ☐ no
Do you eat hormone free meat, milk, eggs? ☐ yes ☐ no Are they grass fed? ☐ yes ☐ no ☐ Sometimes
Do you drink out of plastic bottles? ☐ yes ☐ no Are they ever kept in the car/sun? ☐ yes ☐ no
Do you use the microwave with plastic? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you eat organic vegetables and fruit? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you eat fast food or fried foods? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you eat already prepared food/meals? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you eat other processed foods? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you skip breakfast? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
Do you skip other meals? ☐ Always ☐ Usually ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Current Symptom List

Please check off any of following symptoms you tend to experience:

☐ Lack of appetite ☐ Fatigue after meals ☐ Bloating after meals ☐ Loose/stool diarrhea ☐ Nausea after meals ☐ Mild stomach pains ☐ Often fatigued ☐ Weakness of limbs ☐ Feeling of heaviness ☐ Food allergies ☐ Food sensitivities ☐ Gas ☐ Pale/yellow complex. ☐ Emaciation/very thin ☐ Obsessive tendency ☐ Tend to worry ☐ Crave sweets ☐ Lack of exercise ☐ Light headed ☐ Sweat no reason	☐ Low back pain ☐ Knee problems ☐ Hip problems ☐ Hearing problems ☐ Ear ringing ☐ Frequent urination ☐ Profuse urine	☐ Depression ☐ Moodiness ☐ Anger/rage ☐ Irritability ☐ Frequent sighing ☐ Stuffy chest ☐ Ribside discomfort ☐ Nipple discharge ☐ Nipple pain ☐ Difficulty fall asleep ☐ Pebble-like stool	☐ Weak cough ☐ Shortness of breath ☐ Lack of desire to talk ☐ Frequently catch colds
	☐ Bed wetting ☐ Wake up to urinate ☐ Dribbling urine ☐ Frequent fractures ☐ Bad teeth ☐ Kidney stones ☐ Fearful ☐ Hair loss/thinning		☐ Feel hotter than most ☐ Likes ice cold drinks ☐ Entire face gets red ☐ Rashes on body
☐ Bruise easily ☐ Blood in stools ☐ Uterine prolapse ☐ Other prolapse		☐ Dry flaky skin ☐ Brittle nails ☐ Chapped lips ☐ Dry brittle hair ☐ Poor night vision ☐ Blurred vision ☐ Floaters in eye ☐ Dry eyes ☐ Tendon spasms ☐ Muscle twitches ☐ Numb in limbs ☐ Pale inner eyelid ☐ Pale lips/complex	☐ Dry mouth/throat ☐ Heat in palms/soles ☐ Low grade heat sensat. ☐ Cheeks get flushed ☐ Wake up often
	☐ Night sweats ☐ Hot flashes ☐ Afternoon fever ☐ Red cheeks ☐ Dry mouth ☐ Constipation ☐ Poor memory ☐ Premature grey ☐ Vaginal dryness ☐ Dark eye circles		☐ Gas with foul smell ☐ Yellow skin/jaundice ☐ Yellow eyes ☐ Yellow/green discharge ☐ Foul smelling discharge ☐ Rectal itching
			☐ Testicular/vaginal itch ☐ Pustular acne
☐ Vomiting ☐ Diff. digest oily food ☐ Indigestion ☐ Belching/burping	☐ Impotence ☐ Decreased sex drive ☐ Urgent a.m. stool	☐ Dark/sooty complex ☐ Purple nails/lips ☐ Nosebleeds ☐ Breast lumps ☐ Low ab lumps ☐ Red skin spots	☐ Pale blue lips ☐ Often feel chilled ☐ Cold hands/feet ☐ Cold limbs ☐ Low ab cooler thn upper
☐ Foul breath ☐ Bleeding gums ☐ Heartburn/reflux ☐ Hunger quickly	☐ Heart palpitations ☐ Nightmares ☐ Restless/listless ☐ Excess chest sweat ☐ Low spirit	☐ Hemorrhoids/polyps ☐ Varicose veins	☐ Fainting ☐ Difficulty falling asleep ☐ Headaches ☐ Dizziness/vertigo ☐ Bitter taste ☐ Thirst
		☐ Impulsiveness ☐ Mania	

Which of the above symptoms are the most bothersome? _____

_____

Are there any other symptoms/imbalances you tend to experience? _____

Self Examination – Tongue, Pulse, Urine & Stools

Explain the color and consistency of your urine: _____

Explain the color and consistency of your stools: _____

Explain the frequency of your bowel movements: _____

Stick your tongue out in the mirror and explain what it looks like. Check all that apply:

Body Color: ☐ Pale ☐ Pink ☐ Red ☐ Red tip ☐ Red sides ☐ Deep red ☐ Purple ☐ Purple spots ☐ Red spots ☐ Shiny ☐ Other _____

Coating: ☐ Thin ☐ Medium ☐ Thick ☐ Pasty ☐ Greasy ☐ Sticky ☐ Slimy ☐ Yellow ☐ White ☐ Grey ☐ Black ☐ Peeled spots ☐ No coat ☐ Dry ☐ Moist ☐ Wet

Other: ☐ Quivering ☐ Swollen ☐ Puffy ☐ Thin ☐ Wide ☐ Long ☐ Short ☐ Stiff ☐ Flaccid ☐ Small cracks ☐ Large center crack ☐ Deviated ☐ Sores ☐ Large veins underneath ☐ Other _____

Place three fingers on the pulse of your opposite wrist. Explain what it feels like. Check all that apply:

Pulse: ☐ Can't feel ☐ Very weak ☐ Slightly weak ☐ Some strength ☐ Strong ☐ Very strong ☐ Beats/minute: _____ ☐ Skips beats ☐ Other _____

How are you doing emotionally? Are there any specific emotional states you tend to experience frequently? _____
_____
_____

Is there any additional information you feel is important to share? _____
_____
_____
_____
_____
_____
_____
_____
_____

How did you hear about us? _____