WOMEN'S FERTILITY HISTORY

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Gulf Coast Acupuncture & Fertility

6706 N. 9th Ave, Suite C-5 Pensacola, FL 32504 (850)331-9991

Name:	Date:

Age when menses began: _____

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

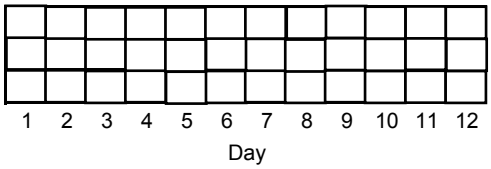
If yes, how? _____

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?



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

	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

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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: _____