

Fertility History and Information

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Acupuncture & Chinese Medicine Center

7600 Parklawn Ave. Suite 321, Edina, MN. 55435 • Phone: 952-820-0877

PART I: (Please check: Are you a Patient / Partner? Female / Male?)

Name: _____ Date of Birth: _____ Today's date: _____

What are your expectations for this visit? _____

How many months have you been having intercourse without any form of birth control? _____ N/A

Menstrual History

What is your menstrual cycle pattern (check all that apply): Regular Irregular Spotting before periods
 Bleeding between periods Light/Heavy periods No periods, (at what age did you stop having them? _____)

How many days are between periods? _____

How many days of bleeding do you have? _____ days

Dates of 1st day of your last 2 menstrual periods? _____/_____/_____; _____/_____/_____

How many periods do you have per year? _____

Do you need medication to bring on a period? No Yes, what type? _____

Pregnancy Summary

Total Number of ALL pregnancies _____ How many children have you had? _____ Number of miscarriages (<20wks) _____

Number of abortions _____ Number of full term deliveries _____ Number of premature (<37 wks) deliveries _____

Date pregnancy ended or delivered	Months to conception	Treatments to conceive	Delivery type—D&C complications	Current partner?
				<input type="checkbox"/> Y; <input type="checkbox"/> N
				<input type="checkbox"/> Y; <input type="checkbox"/> N
				<input type="checkbox"/> Y; <input type="checkbox"/> N
				<input type="checkbox"/> Y; <input type="checkbox"/> N
				<input type="checkbox"/> Y; <input type="checkbox"/> N

Contraceptive and Sexual History

None Condoms-dates of use _____ Birth control pill-date of use _____, Complications _____

Never used birth control pills Injectable contraception (Depo-Provera, Lunelle, etc)-dates of use _____

Others _____

Are you sexually active? Yes No; How many times do you have intercourse per week? _____/wk; None N/A

Have you used over-counter ovulation kits to time intercourse? Yes No, Unable to get LH Surge Positive

Do you have pain with intercourse? Yes No; Use lubricants (K-Y Jelly, etc) during intercourse

Have you ever had an abnormal pap smear? Yes No, If Yes, When _____

Have you ever had a cervical biopsy? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydial infection? Yes No, If Yes, When _____

Do you have a chronic vaginal discharge? Yes No

Do you have sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease (PID)? Yes No, If Yes, Were you treated for it? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No, When/Treatment _____

Have you ever been diagnosed with endometriosis? Yes No, When/Treatment _____

Have you ever been diagnosed with pelvic adhesions? Yes No, When/Treatment _____

Have you ever been diagnosed with any pelvic abnormalities? When/Treatment _____

PRIOR INFERTILITY TESTING AND TREATMENT

(Prior to your initial visit, please fill out "ACM Center Medical Records Release Form" and send to your Doctor's office. We also request you bring any copies of lab. Testing/Diagnosis reports)

Have you had prior infertility testing or /and treatments? Yes No; What is your infertility Diagnosis? _____

Prior Tests (check all that apply)

- Basal body temperature chart (date _____/results _____, bring your BBT Charts @ 1st visit)
- Thyroid test (date _____/results _____) Day 3 Blood test for FSH (date _____/results _____)
- AMH (date _____/results _____) (Progesterone blood test (date _____/results _____))
- Prolactin blood test (date _____/results _____) Hysterosalpingogram (HSG) (date _____/results _____)
- Hysteroscopy surgery (date _____/results _____) Laparoscopiesurgery (date _____/results _____)

Prior Treatment (check all that apply)

Treatment Type	# of cycles	Date From (mo/yr) to (mo/yr)	Outcome
<input type="checkbox"/> Intrauterine insemination (IUI) NO MEDICALTION		to	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Clomid/Letrozole with time intercourse		to	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Clomid/Letrozole with insemination (IUI)		to	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Stimulation Medication Injection with IUI		to	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Completed in vitro fertilization (IVF) cycle(s)			
1. # eggs _____; #embryos transferred____; #frozen_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
2. # eggs _____; #embryos transferred____; #frozen_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
3. # eggs _____; #embryos transferred____; #frozen_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
4. # eggs _____; #embryos transferred____; #frozen_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Frozen embryo transfers			
1. # embryo transferred_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
2. # embryo transferred_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
3. # embryo transferred_____		_____/_____	<input type="checkbox"/> Pregnant: Delivered/ Ectopic/ Miscarriage; <input type="checkbox"/> No pregnant
<input type="checkbox"/> Canceled IVF attempt(s)			
<input type="checkbox"/> Any other prior treatment (describe):			

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

Is your partner supportive of your infertility treatments? Yes No; describe: _____

On a scale of 1-10 (10=worst), estimate the level of stress you feel due to infertility. _____

Describe any emotional, marital or sexual problems caused by your infertility. _____

Do you have a future IUI or IVF procedure scheduled? Yes No; If yes, please list the dates.

Last day of Birth Control Pill _____/_____/_____ First day of Stimulation Medication _____/_____/_____

Date (the week) of IUI _____ Date (the week) of IVF retrieval _____/_____/_____

Date (the week) of Frozen Embryo Transfer (FET) _____

Do you have any other comments? _____

Signature _____

Date _____

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PART II: (Please check: Are you a Patient / Partner? Female / Male?)

Name: _____ Date of Birth: _____ Today's date: _____

Have you seen an Urologist for evaluation? ___Yes ___No When _____; Physician Name: _____

Have you had a semen analysis? ___Yes ___No If Yes, Please list most recently results.

Date	Volume	Count	Motility	Morphology	Comments
1.					
2.					
3.					

Have you ever fathered any prior pregnancies? ___Yes ___No Outcome _____

How would you define your sexual energy? Below normal _____ Normal _____ High _____

Do (or did) you have an undescended testicle? ___Yes ___No; Comments: _____

Have you ever been diagnosed with a varicocele? ___Yes ___No; Comments: _____

Have you ever had any urologic surgeries? ___Yes ___No; Comments: _____

Have you experienced erectile dysfunction? ___Yes ___No; Comments: _____

Have you experienced difficulty with ejaculation? ___Yes ___No; Comments: _____

Have you had exposure to any known environmental toxins or hormones? ___Yes ___No; Comments: _____

Do you regularly experience nocturnal emission? ___Yes ___No; Comments: _____

Do you have high cholesterol? ___Yes ___No; Comments: _____

Have you ever had spinal injury? ___Yes ___No; Comments: _____

Have you experienced a high fever in the last 6 months? ___Yes ___No; Comments: _____

Do you currently have any prostate conditions? ___Yes ___No; Comments: _____

Have you had your testosterone levels checked? ___Yes ___No; Result: When _____, below ___ normal ___

Have you ever taken testosterone supplements/drugs? ___Yes ___No; Result: When _____, What _____

Do you smoke cigarettes? ___Yes ___No, How many/day? _____ How many years? _____, Quit/when _____

Do you drink alcohol? ___Yes ___No, How many drinks/week _____

Have you casually used marijuana, cocaine, or any other similar drug? ___Yes ___No, (describe _____)

Have any of your immediate family members had difficulty conceiving a child? ___Yes ___No, describe _____

On a scale of 1-10 (10=worst), estimate the level of stress you feel due to infertility _____ due to work _____

List your current medical problem(s) _____

List your current medications _____

List your current herbs/vitamins or health store supplements? _____ No _____

Do you have any other comments? _____

Male Patient/Partner Signature _____

Date _____