Fertility History and Information

Acupuncture & Chinese Medicine Center

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/Abortions (<20wks)_____
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?
				___Y; ___N
				___Y; ___N
				___Y; ___N
				___Y; ___N

Contraceptive and Sexual History

___None ___Condoms-dates of use_____ ___Birth control pill-date of use_____,
___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 _____

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_____) ___Laparoscopysurgery (date_____/results_____)

Prior Treatment (check all that apply)

Intrauterine insemination (IUI): Yes____ No_____; # of cycles completed_____, When _____, # of pregnant _____

Completed in vitro fertilization (IVF) cycle(s): Yes ___, No _____;

# of IVF-Retrieval Cycles: _____, When _____

# of FET Cycles: _____, When _____; Outcome _____

Other _____

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 be 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 _____