Fertility History and Information

Acupuncture & Chinese Medicine Center
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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
(Please bring any copies of the 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 a Urologist for evaluation? ___Yes ___No When_____; Physician Name:_____

Have you had a semen analysis? ___Yes ___No If Yes, please list the most recent 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 a 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 _____