

Name: _____ DOB: _____ Age: _____

Address: _____

Best Phone #s: _____ Email: _____

Emergency Contact _____ Relation _____ Phone: _____

Relationship status? _____ How long? _____ What is your occupation? _____

How did you hear about us? _____

Have you had acupuncture before? (Yes/No) When was your last treatment? _____

Who is your gynecologist? _____

Who is your Reproductive Endocrinologist if applicable? _____

How long have you been attempting to get pregnant? _____

What is your Blood Type (A, B, AB, O) ? If unknown, write unknown _____

General History:

<input type="checkbox"/> Abnormal Pap Smears	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Other Cancers
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Pace Maker
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Pelvic Inflammatory Disease
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Fertility Issues	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Fibroids/ Polyps/ Myomas	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Urinary Incontinence
<input type="checkbox"/> Herpes	<input type="checkbox"/> Other _____

Family History:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Fertility Issues
<input type="checkbox"/> Autoimmune Diseases	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Breast Cancers	<input type="checkbox"/> Ovarian Cancers
<input type="checkbox"/> DES Usage	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other Cancers
<input type="checkbox"/> Endometriosis/ Fibroids	<input type="checkbox"/> Thyroid Conditions

Menstrual History:

Date of last menstrual period: _____

At what age did you begin your menstruation? < 11 11 12-14 15 >15

Is your menstrual cycle regular? (i.e.: 28 days long?) (Yes/ No)

What is the duration of your flow?	<input type="checkbox"/> <3 days	<input type="checkbox"/> 3-6 days	<input type="checkbox"/> >6 days
How is your overall flow?	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
How is your clotting during menstruation?	<input type="checkbox"/> None	<input type="checkbox"/> Few	<input type="checkbox"/> Moderate
How would you rate the size of your clots?	<input type="checkbox"/> Small	<input type="checkbox"/> Medium	<input type="checkbox"/> Large
How are your menstrual cramps?	<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
How long do your cramps last?	<input type="checkbox"/> Hours	<input type="checkbox"/> Days	

Where are your cramps? (Please check all that apply.)

- None Pelvic Recto-Vaginal (spotting) Low Back Thigh/ Leg

Do you have irregular bleeding outside of your menstruation? (Yes / No)

What are the symptoms you experience pre-menstrually? (Please check all that apply.)

- Anxiety Mood Swings Nervousness Fluid Retention
 Headaches Food Cravings Tender Breasts Difficulty Sleeping

Fertility History

What symptoms do you experience during ovulation? (Please check all that apply.)

- None Vaginal Discharge Increased Libido Pelvic Twinge / Pain

How many total pregnancies? _____ How many pregnancies carried to term? _____

How many pre-term pregnancies? _____ How many abortions? _____

How many miscarriages? _____ How many living children? _____ Ages: _____

Have you had the following procedures or tests? What were the results? _____

- FSH / E/2? Score: _____ How recent? _____
 Hysterosalpingogram (HSG) ? _____
 Hysteroscopy? _____
 Cervical Conization? _____
 Dilation /Curettage (D&C)? _____
 Laparoscopy? _____
 Mammography? _____
 Pelvic / Abdominal Ultrasounds? _____
 Pregnancy Termination? _____

Have you had the following Procedures? (Please check all that apply & indicate when.)

<input type="checkbox"/> Stimulated cycle w/out IUI _____	<input type="checkbox"/> ZIFT _____
<input type="checkbox"/> Stimulated IUI _____	<input type="checkbox"/> IVF _____
<input type="checkbox"/> Non- Stimulated IUI _____	<input type="checkbox"/> IVF/ Donor _____
<input type="checkbox"/> GIFT _____	<input type="checkbox"/> _____

Partner's History

Has your partner / husband ever had a semen analysis? (Yes / No)

What were the results? Not applicable Abnormal Normal

Has your partner / husband ever had any of the following? (Please check all that apply.)

- Varicocele Prostate Problems Lower Back Pain Chronic Pelvic Pain
- Frequent Headaches Sedentary Lifestyle

Personal Questionnaire

Do you have a history of abuse? (Yes / No)

Are you satisfied with your current libido? (Yes / No)

Are you well lubricated during intercourse? (Yes / No)

Do you experience pain during penetration? (Yes / No)

Do you have bleeding following intercourse? (Yes / No)

Do you have trouble sleeping? (Yes / No)

Current Medications/Supplements

General Symptoms

- Poor appetite
- Heavy appetite
- Strongly like cold drinks
- Strongly like hot drinks
- Peculiar taste
- Cravings
- Sweats easily
- Night sweats
- Poor sleep
- Dream disturbed sleep
- Heavy sleep
- Bodily heaviness
- Chills
- Fever
- Bleed or bruise easily
- Cold hands or feet
- Poor circulation
- Vertigo or dizziness
- Fatigue
- Lack of strength
- Shortness of breath
- Muscle cramps

Head, Eyes, Ears, Nose, Throat

- Headaches
- Migraines
- Facial pain
- Glasses
- Poor vision
- Blurred vision
- Eye strain
- Red eyes
- Itchy eyes
- Spots in eyes
- Glaucoma
- Night Blindness
- Sores on lips or tongue
- Swollen glands
- Dry mouth
- Excessive saliva
- Recurrent sore throat
- Lumps in throat
- TMJ
- Teeth problems
- Grinding teeth
- Sinus problems
- Enlarged thyroid
- Excessive phlegm
- Earaches
- Ringing in ears
- Poor hearing
- Gum problems

Respiratory

- Difficulty breathing when lying down
- Shortness of breath
- Tight chest
- Cough Wet or dry?
- Color of phlegm _____
- Coughing blood
- Asthma/ wheezing
- Pneumonia

Cardiovascular

- High Blood Pressure
- Tight chest
- Blood clots
- Fainting
- Difficulty breathing
- Heart palpitations

Irregular heart beat

Gastrointestinal

Bowel movements:

Frequency: _____

Texture/Form _____

Color: _____

Odor _____

Diarrhea

Constipation

Laxative use

Mucous in stools

Itchy anus

Anal fissures

Black stools

Bloody stools

Gas

Bloating

Intestinal pain or cramping

Burning anus

Rectal pain

Hemorrhoids

Nausea

Vomiting

Acid regurgitation

Bad breath

Hiccup

Musculoskeletal

Joint pain

Muscle pain

Neck/ shoulder pain

Upper back pain

Lower back pain

Rib pain

Limited range of motion

Limited use

Skin and Hair

Rashes

Eczema

Dandruff

Hair loss

Change in hair / skin texture

Hives

Psoriasis

Itching

Fungal infections

Ulcerations

Acne

Neuropsychological

Seizures

Poor Memory

Irritability

Numbness

Depression

Anxiety

Easily stressed

Tics

Abuse survivor

Considered/ attempted suicide

Genito-urinary

Pain when urinating

Blood in urine

Venereal disease

Increased libido

Impotence

Frequent urination

Bedwetting

Unable to hold urine

Decreased libido

Premature ejaculation

Wake to urinate

Incomplete urination

Kidney stone

Nocturnal emission

Your Diet

Appetite Low Strong Too Busy to Notice

Coffee (#/day) _____

Sugar

Salty food

Soft Drinks

Artificial sweeteners

Processed/Packaged foods?

Thirst for water

of glasses per day _____

meat (#/wk) _____

dairy (#/wk) _____

Yesterday's Breakfast _____ Lunch _____

Dinner _____ Snacks _____ Is this a typical day? Y or N

Your Lifestyle

Alcohol

Tobacco

Regular Exercise:

Type _____ Frequency: _____

Drugs

Marijuana

Stress

Occupational Hazards