WEALTH ACUPUNCTURE
Your health is your greatest wealth

FERTILITY HEALTH HISTORY

Date_____ Name_____

How long have you been trying to conceive? _____

Have you had a fertility workup (hormone lab tests) etc.? _____

If so, what were the results? _____

Have your fallopian tubes been evaluated medically? _____ If so, what were the results? _____

Has your uterus ever been diagnosed as (circle one): leaning forward leaning to the left

leaning to the right retroverted prolapsed

Have you had a diagnosis related to infertility? _____ If so, what is it? _____

Do you have a single partner with whom you have been trying to conceive? ____ What is his date of birth? _____

Has he had a fertility work up? _____ If so, what were the results? _____

Is your partner supportive of your wish to conceive? _____

Date of first day of last menstrual period _____

Age of first menstrual period _____ How many days are there in between periods? _____

Do you have painful periods? _____ If yes, how many days does the pain last? _____

How many days do you normally bleed? _____ Do you spot or bleed before or between periods? _____

How heavy is the bleeding? (Circle one) Light Normal Heavy

What color is the blood? (Please circle) Light red Red Dark Red Purple Brown Black

Is there clotting? _____

Have your cycles changed since they began? _____ If so, how? _____

Do you ovulate on your own? _____ On what day of your cycle? _____

Have you ever been diagnosed with any of the following: (If yes, please circle) uterine fibroids

endometriosis uterine polyps pelvic adhesions pelvic abnormalities

chlamydia other veneral disease (if so, which one: _____)

Have you ever been diagnosed with pelvic inflammatory disease? _____

Did you receive treatment? _____ What kind? _____

Do you experience bowel changes with your period? _____ If so, how? _____

Does your face break out before or during your period? _____

Do you experience breast tenderness: (Please circle) premenstrually with your period with ovulation

Do you get frequent yeast infections? _____ Do you have chronic vaginal discharge? _____

Date of last pap smear _____ Have you ever had an abnormal pap smear? _____ If so, year(s)_____

How many pregnancies have you had? _____ Year(s) _____

How many children do you have?_____ Age(s)_____

How many abortions have you had?_____ Year(s)_____

How many miscarriages have you had?_____ Year(s)_____

How many times has a D&C been performed?_____ Year(s)_____

Have you had any tubal operations? _____ Year (s) _____

Have you ever taken oral contraceptives? _____ If so, what type and for what dates? _____

Have you ever had an IUD _____ If so, for what dates? _____

Have you taken medication to help you ovulate? _____ If so, for what dates? _____

Are you presently taking steroids? _____

Have you been exposed to environmental hormones or toxins? _____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? _____

Have you taken any other medications for gynecological conditions?

Medication	Reason	For how long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you douche regularly? _____ Use vaginal lubricants? _____

Do you have any of the following: (If yes, please circle) Stressful occupation Family stress
Other excessive stress Excessive facial hair Excessively oily skin Genital sores
Excessive loss of head hair Discharge from nipples

Are you more than 20% over or below your ideal body weight? _____

How is your sexual energy? (please circle one) Low Normal High

What is your opinion of yourself? _____

On a scale of 1-10 (1 being the lesser, 10 the greater), please rate yourself:

Faith _____ Hope _____ Generosity _____ Sense of Humor _____ Fear _____ Grief _____
Sense of fun _____ Charity _____

Please describe the most negative emotion you experience _____

When do you most often feel this emotion?_____ Where are you? _____

Do you have a spiritual practice? _____

How are you feeling about your personal fertility journey? _____

_____

Is there anything else you would like me to know? _____

_____

_____

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