Living Chi – Acupuncture and Chinese Herbal Medicine

Female Fertility Patient History

Important: The information on this form will help your acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

General Patient Information (*All of the information provided is strictly confidential – see permission to share medical information section*)

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Primary Telephone Number: _____ Alternative Phone # _____

E-Mail: _____ Today's Date ____ / _____ / _____

Personal and Contact Information

Address: _____ City: _____ State: _____ Zip:_____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Spouse's Name: _____ Spouse's Age: _____ Occupation: _____

Spouse's Place of Employment: _____

Has your husband/partner had a semen analysis? _____ Results: _____

In case of emergency, whom should we notify? _____Relationship: _____

Contact Number: _____ Address: _____

Number of

Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Ectopic(s)	
Failed IUI's	
Failed IVF's	

Ob/Gyn: _____

Reproductive Endocrinologist: _____

Midwife: _____

Menstrual Cycle

How long have you been trying to get pregnant? _____ Age menstruation began: _____

(please circle one) My periods are: a) Like clockwork b) Somewhat regular c) Erratic Number of days of bleeding during period: _____

Number of days in menstrual cycle: _____ If your cycle is erratic: Shortest # of days in cycle: _____ Longest # of days in cycle: _____

Menstrual bleeding tends to be: a) Light b) Normal c) Heavy On what cycle day do you typically ovulate? _____

During ovulation, is your cervical mucus (circle all that apply) a) clear b) cloudy c) yellow d) abundant e) scanty f) non existent g) stretchy

Is there clotting with your period? ☐ Yes ☐ No Do you have spotting before or between periods? ☐ Yes ☐ No

Do you regularly experience PMS? ☐ Yes ☐ No (Check all PMS symptoms you get)

☐ Breast tenderness ☐ Diarrhea ☐ Acne ☐ Bloating ☐ Constipation ☐ Back Pain
☐ Dizziness ☐ Fatigue ☐ Mood Swings ☐Pain and Cramps ☐ Irritability ☐ Headache or Migraine

☐ Food Cravings for:_____

Previous Gynecological Surgeries - *Check any surgical procedure that you have had*

☐ Dilation & Curettage (D&C) ☐ Laparoscopy (uterine fibroids) ☐ Falloposcopy
☐ Mymectomy ☐ (HSG) Hysterosalpingogram ☐ Neosalpingostomy
☐ Hysteroscopy ☐ Laparoscopy (endometriosis) ☐ Tuboplasty
☐ Laparoscopy (ovarian cysts) ☐ Other(s):_____

Previous Diagnostic Assessments - *Check any diagnosis received by your OB/GYN or Fertility Doctor*

☐ Advanced Maternal Age ☐ Luteal Phase Defect ☐ Amenorrhea
☐ Menorrhagia ☐ Anovulation ☐ Ovarian Cyst (single)
☐ Anti-sperm Antibodies ☐ Ovarian Cyst (multiple) ☐ Autoimmune Oopharitis
☐ Pelvic Inflammatory Disease (PID) ☐ Cervical Stenosis ☐ Ovarian Hyperstimulation Syndrome (OHSS)
☐ Clotting with Period _____ ☐ Phospholipid Antibodies ☐ Delayed Cycles ____ - ____ Days
☐ Menstrual Pain (mild) ☐ Menstrual Pain (moderate) ☐ Menstrual Pain (severe)
☐ Premature Ovarian Failure (POF) ☐ Resistant Ovarian Syndrome ☐ Polycystic Ovarian Syndrome (PCOS)
☐ Elevated FSH _____ ☐ Hostile Cervical Mucus ☐ Endometriosis (mild, moderate, severe)
☐ Short Cycles ____ - ____ Days ☐ Erratic Cycles ____ - ____ Days ☐ Spotting between periods ____ - ____ Days
☐ Unexplained Infertility ☐ Fallopian Tube Blockage ☐ Uterine Fibroids
☐ Uterine Septum ☐ Habitual Miscarriage ☐ MTHFR (Methylenetetrahydrofolate Reductase)
☐ Hyperprolactinemia ☐ Other(s): _____

List the Fertility Drugs you have taken: _____

Medications you use currently: _____

Have you been tested for chlamydia? ☐ Yes ☐ No - Results: ☐ Positive ☐ Negative

General Health Information

Major Health Complaint(s). Other than your primary reproductive concerns, please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms

1. _____
2. _____
3. _____
4. _____

Additional Health Complaints / Symptoms

1. _____
2. _____
3. _____
4. _____

Please explain how these conditions affect or impair your daily activities: _____

_____

Describe your symptoms when they are at their worst: _____

_____

Are there any other complaints or conditions that you would like us to know about? _____

_____

Medical Conditions and History (Check any conditions that you have had in the past, or are currently experiencing):

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic fever	☐ Heart Disease
☐ Stroke	☐ Vein condition	☐ Thyroid disorder	☐ Asthma	☐ Pneumonia
☐ Tuberculosis	☐ Emphysema	☐ Hepatitis	☐ Gonorrhea	☐ Mumps
☐Bleeding or Hemorrhage	☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Auto Immune Disease	☐ Epilepsy
☐ High Fever	☐ Hepatitis	☐ Hypertension	☐ Paralysis	☐ Cancer
☐ Migraines	☐ Mental Illness	☐ Lung disease	☐ Heart disease	☐ Liver disease
☐ Kidney disease	☐ Gonorrhea	☐ Chlamydia	☐ Irregular Pap Smear	☐ High Cholesterol

☐ Other _____

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Body Temperature (Kidney Organ System)

☐ Cold hands	☐ Hot body temperature	☐ Profuse perspiration	☐ Perspire easily	☐ Cold feet
☐ Cold body temperature	☐ Lack of perspiration	☐ Night time urination	☐ Sweaty palms	☐ Afternoon flushing
☐ Night sweating	☐ Sweaty feet	☐ Hot flashes	☐ Strong thirst	

Energy and Stamina (Lung and Kidney System)

☐ Easily fatigued	☐ Lethargy	☐ Easily prone to illness	☐ Shortness of breath	☐ Wheezing
☐ Sweating without exertion	☐ Chronic allergies	☐ Frequent colds / flu / sinus infections		

Blood Function (Liver, Heart and Spleen System)

☐ Dizziness	☐ Tingling in extremities	☐ Itchy or dry skin	☐ Blurry vision	☐ Poor night vision
☐ Poor memory	☐ Scanty menses	☐ Tinnitus	☐ Floaters	☐ Fainting
☐ Weak or brittle nails	☐ Difficulty concentrating			

Heart Function

☐ Heart palpitations	☐ Manic moods	☐ Forgetfulness	☐ Tongue ulcers	☐ Anxiety
☐ Restless dreams	☐ Hallucinations	☐ Speech impediment	☐ Mental restlessness	☐ Insomnia
☐ Depression	☐ Severe shyness	☐ Chest Pain	☐ Arrhythmia	☐ Hemophilia
☐ Rapid Heart Beating	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Mitral valve prolapse	☐ Heart Murmur

Lung Function

☐ Persistent cough	☐ Chronic allergies	☐ Dry or flaky skin	☐ Headaches	☐ Nosebleeds
☐ Nasal dryness	☐ Sneezing	☐ Difficulty breathing	☐ Sinus congestion	☐ Sore throats
☐ Wheezing	☐ Cigarette smoking			

Allergies to: ☐ Mold ☐ Cedar ☐ Pet fur ☐ Dust ☐ Pollen ☐ Oak ☐ Hay Fever ☐ Environmentally Sensitive

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? ☐ Yes ☐ No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

☐ Low or weak appetite	☐ Abdominal bloating	☐ Gurgling in intestines	☐ Hemorrhoids	☐ Abrupt weight gain
☐ Fatigue following a meal	☐ Hypoglycemia	☐ Abrupt weight loss	☐ Strong food cravings	☐ Gas
☐ Bruise easily	☐ Indigestion			

Stomach Function

☐ Stomach ache	☐ Bad breath	☐ Stomach ulcer	☐ Nausea	☐ Acid reflux
☐ Bleeding gums	☐ Belching	☐ Vomiting	☐ Ravenous appetite	☐ Heartburn
☐ Hiccups	☐ Mouth ulcers	☐ Tooth pain		

Bowel Function and Elimination (Intestinal Function)

☐ Loose stools ☐ Constipation ☐ Difficulty moving bowels ☐ I.B.S. or Colitis ☐ Diarrhea
☐ Blood in stools ☐ Small, hard, dry stools ☐ Chron's Disease ☐ Incomplete stools ☐ Mucous in stools
☐ Less than 1 BM/ Day ☐ Eating Disorder

Accumulated Dampness

☐ Mental fogginess ☐ Swollen hands ☐ Edema in the legs ☐ Mental sluggishness ☐ Swollen feet
☐ Edema in the abdomen ☐ Poor mental focus ☐ Joint stiffness / ache ☐ Chest congestion ☐ General Fatigue
☐ Heaviness of the head, the limbs, or of the whole body ☐ Symptoms worsen in rainy weather

Liver and Gall Bladder Function

☐ Chest pain ☐ Irritability ☐ Depression ☐ Skin rashes ☐ Chest tightness
☐ Easy to anger ☐ Pain in the ribcage ☐ Acne ☐ All over body tension ☐ Easily frustrated
☐ Heaviness in ribcage ☐ Headaches ☐ Muscle spasms ☐ Chronic neck tension ☐ Convulsions
☐ Migraines ☐ Muscle cramps ☐ Numbness / tingling ☐ Shoulder tension ☐ Gall stones
☐ Seizures ☐ Lump in throat ☐ Ringing in ears ☐ Eye pain / dryness
☐ Alternating diarrhea and constipation ☐ Easily overwhelmed by stressful circumstances

Please list any non-prescription or recreational drugs you currently take _____

Eyes (Liver Function)

☐ Itchy eyes ☐ Grittiness ☐ Bloodshot ☐ Far sighted ☐ Dry eyes
☐ Poor night vision ☐ Seeing spots ☐ Astigmatism ☐ Watery eyes ☐ Red and irritated
☐ Near sighted ☐ Glaucoma

Kidney and Urinary Bladder Function

☐ Frequent cavities ☐ Weak knees ☐ Cold lower back ☐ Broken / loose teeth ☐ Hair loss
☐ Knee soreness ☐ Cold hips / buttocks ☐ Early graying of hair ☐ Weak bones ☐ Low back pain
☐ Cold knees ☐ Hearing loss ☐ Ringing in the ears ☐ Prostate problems ☐ Incontinence
☐ Quick to fear / fright

Urinary Function

☐ Normal color ☐ Reddish color ☐ Small amount ☐ Night-time urination ☐ Dark Yellow
☐ Cloudy ☐ Large amount ☐ UTI / Pain or burning ☐ Clear color ☐ Strong odor
☐ Very frequent ☐ Hesitancy ☐ Difficulty initiating the stream of urination ☐ Dribbling
☐ Weak stream

Libido Function

☐ Normal ☐ High sex drive ☐ Diminished sex drive ☐ Pain with intercourse ☐ Vaginal dryness
☐ Infertility ☐ Fatigue following sexual activity

Fertility Stress Assessment

Managing stress effectively is an essential component of healthy reproduction. The more effectively stress is managed, the more your body and mind become relaxed, receptive and fertile.

How would you rate your current stress level? (1 being the least, 10 being the highest) 1 2 3 4 5 6 7 8 9 10

In w hat areas of your life do you feel the most stressed? Circle all that apply: Fertility process - Job/Career - Financial

Partner/Spouse relationship - Parents/Family - Friends - Other(s): _____

How does this stress impact your:

Health: _____

Thoughts about self: _____

Thoughts about others: _____

Feelings/Mood: _____

Actions: _____

How would you describe your current level of hopefulness towards attaining your fertility goals?

(1 being the lowest feeling of hope, and 10 being the most hopeful) 1 2 3 4 5 6 7 8 9 10

W hat are your main source(s) of support? Spouse/Partner - Family - Friends - Workplace - ChurchSupport group - Therapist –

God/Prayer - Myself (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? Massage therapy - Physical exercise - Meditation –

Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Medical Evaluation

I have been evaluated by a physician, OB/GYN, Reproductive endocrinologist for the condition being treated within the last twelve months.

☐ Yes ☐ No

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information in each of the following area. Many of our patients are under the care of an OB/GYN, a Reproductive Endocrinologist, or a Fertility Specialist. In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your OB/GYN, Reproductive Endocrinologist and/or Fertility Specialist?

☐ Yes ☐ No

_____ _____

Patient Signature Date