養 藝
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INTEGRATIVE HEALING ARTS
ACUPUNCTURE • HERBAL MEDICINE • MASSAGE THERAPY
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Women's Fertility History

A. Menstruation History & Health

At what age did you start menstruation?_____

What type _____How long? _____ years

Did you take birth control pills? Yes ☐ No ☐

How many days is your menstrual cycle (i.e. 28-30): _____ regular? Yes ☐ No ☐

Based on the days of **FULL flow bleeding** (not the spotting/tapering before or after menstruation):

Number of days of flow/bleed?:_____ *(The number of times in full flow days you change your pad/tampon)*

Blood color: light red/pink ☐ bright red ☐ dark red/purple ☐ brown ☐

Blood volume: light ☐ normal ☐ heavy ☐

Clotting? Yes ☐ No ☐ What size are the clots?_____(e.g. chicken liver size?)

Discomfort/pain during period ☐ Other:_____

Cramps: none ☐ mild ☐ medium ☐ severe ☐

Spotting between periods ☐ Discomfort/pain before period ☐

Any vaginal discharge? Yes ☐ No ☐ Amount _____ Color _____ Frequency _____

PMS please check all that apply:

Emotional ☐ depression ☐ irritability ☐ weepiness ☐ insomnia ☐ fuzzy ☐ anger ☐

Other: _____

Breast tenderness ☐ Lumps in the breast ☐ Congested breast ☐

Blood or mucous discharge from breasts? Yes ☐ No ☐ Amount_____ Frequency _____

Headaches ☐ migraines ☐ fatigue ☐ facial skin break out ☐

Weight gain ☐ gas & bloating ☐ fluid retention ☐ Sweating ☐ flashing ☐ temperature changes ☐

Other: _____

Bowel changes ☐ loose ☐ constipation ☐ both ☐

What makes these symptoms better? _____

Vaginal itching/burning ☐

Yeast infections? Yes ☐ No ☐ Recurrent? Yes ☐ How often? _____

Bladder infections? Yes ☐ No ☐ Recurrent? Yes ☐ How often? _____

STD Yes ☐ No ☐ HPV Yes ☐ No ☐

Herpes? Yes ☐ No ☐ PID Yes ☐ No ☐

B. Fertility History

How long have you been trying to conceive? _____ What day of your cycle do you ovulate?_____

Have you received a medical diagnosis relating to infertility? Yes☐ No☐

Diagnosis? _____

List the number of:

Pregnancies?_____ Number of deliveries? _____ Miscarriage(s)? _____ Abortion(s)/Terminations?____

Ectopic?_____ D&C?_____

Pregnancy complications? Please describe: _____

Check all that apply:

☐Abnormal Pap Smear ☐Endometriois/ Adhesions ☐ PCOS

☐Elevated FSH ____ ☐ FSH level day ☐ Low progesterone level

☐Uterine Fibroids/ Polyps ☐ HCG ☐HSG

What treatments have you received for this and/ or other conditions?_____

_____

D. Fertility treatments (including cancelled cycles):

Date	Natural, IUI, IVF, Other	Medication Used	# of mature eggs/ follicles	Pregnancy Yes/No	If miscarried, indicate at which week	Other comments & locations

C. Male Fertility

Has your husband/ partner had a fertility work up? Yes☐ No☐

Results? _____

Is your partner supportive of your wishes to conceive? Yes☐ No☐

E. Fertility Plan for the next 6 Months: