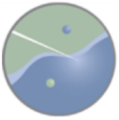

Point Flow Acupuncture
404 S. 2nd St #1A
St. Charles, Il 60174
630-444-1488 ~ www.point-flow.com

Women's Fertility History

Date ________________________

Name ____

Address ________________________ City _______________ State/Zip _______________

Home Phone ___________________ Cell Phone _____________________ Work Phone _____________

Email Address ____

May we place you on our email newsletter and send you a copy of our FREE ebook? Yes ☐ No ☐

Who referred you to our practice? ____

Primary Gynecologist ____

Primary Reproductive Endocrinologist ____

Birth Date ______________ Marital Status __________ Height ___________ Weight _________

Profession ____

How long have you been trying to conceive? ____

Do you have a Western diagnosis? ____

Have you ever had acupuncture treatment for any other condition? ______________________________

Menstrual History

At what age did you start to menstruate? ______________________________________

When you started your periods where they every 28 days? _______ Longer? __________ Shorter? _________

How would you describe your cycles? (circle the number which best describe your cycle the first few years of your periods)

1. Normal, I always knew when the bleeding would start, never had heavy bleeding, no mood changes.
2. I had mood changes, heavy bleeding, and used a lot of tampons.
3. I had severe cramping, terrible mood changes, headaches, heavy bleeding, had to miss school.
4. Barely knew when I would get my periods, little bleeding, no mood changes but felt very tired for several days.
5. Other (please explain) ____

How would you describe your periods now?

☐ Normal ☐ Heavy ☐ Light ☐ Cramping

Do you experience anytime during your cycle?

- ☐ Mood swings
- ☐ Breast tenderness
- ☐ Low back pain
- ☐ Migraines
- ☐ Bloating
- ☐ Yeast infection
- ☐ Urinary tract infection
- ☐ Tension headaches
- ☐ Spotting
- ☐ Breast discharge
- ☐ Vaginal discharge
- ☐ Itching & burning
- ☐ Pain with intercourse

Gynecological History

Do you have or have you ever had any of the following?

- ☐ Pelvic infection
- ☐ Apendicitis
- ☐ Gonorrhea
- ☐ Ovarian cysts
- ☐ Chlamydia
- ☐ Colitis or enteritis
- ☐ Syphilis
- ☐ Toxoplasmosis
- ☐ Endometriosis
- ☐ Uterine fibroids
- ☐ Cytomegalovirus(CMV)
- ☐ Pelvic adhesions
- ☐ Abnormal uterine shape
- ☐ Cervicitis
- ☐ Recurrent vaginitis
- ☐ Trichomonas
- ☐ Genital herpes
- ☐ Abnormal Pap
- ☐ Polyps
- ☐ Mittleschmerz
- ☐ Pelvic inflammatory disease
- ☐ Tilted uterus
- ☐ Polycystic ovaries

Have you ever had any pelvic surgery? What type? ______________________________

Have you ever used an IUD?______________________________

Have you ever used the Oral Contraception Pill?______________________________

How many years? ____________________

When did you last use it? ______________

Obstetrical History

Number of pregnancies	
Number of term pregnancies	
Miscarriages	
Abortions	

Ectopic Pregnaqncy	
Molar Pregnancy	

Did you have any problems with your pregnancies? ______________________________

Were your pregnancies full term? ______________________________

Approximately how long did you labor? ______________________________

Did you have a C-Section or vaginal delivery?______________________________

Was your delivery difficult for you? ______________________________

Were any of your deliveries premature? ______________________________

Did you develop gestational diabetes or high blood pressure?____________________

Did you gain more than 35 pounds during your pregnancy? ____________________

Childhood

Question	Yes	No	Don't Know	Comment
When your mother was pregnant with you, did she:				
Smoke Tobacco?				
Drink alcohol?				
Take estrogen?				
Were you a full tern baby?				
A preemie?				
Breast fed?				
Bottle fed?				
As a child, did you eat a lot of sugar and/or candy?				

General Health

Have you or have you had any of the following>

- Cancer ☐
- Heart disease ☐
- Heart murmur ☐
- Tuberculosis ☐
- Ulcers ☐
- Rubella ☐
- Seizures ☐
- Anemia ☐
- Fatigue ☐
- Constipation ☐
- Cough ☐
- Arthritis ☐
- Allergies ☐
- Diabetes ☐
- Rheumatic fever ☐
- Asthma ☐
- Hepatitis ☐
- Colitis/Crohn:s ☐
- Mumps ☐
- Stroke ☐
- Thyroid disease ☐
- Acne ☐
- Diarrhea ☐
- Wheezing ☐
- Paralysis ☐
- Thyroid disease ☐
- Hypertension ☐
- Scarlet fever ☐
- Pneumonia ☐
- Liver problems ☐
- Kidney disorder ☐
- Chicken pox ☐
- Blood clots ☐
- IBS ☐
- Rash ☐
- Hair loss ☐
- Sinus problems ☐
- Breast tumors ☐
- Breast cancer ☐
- High cholesterol ☐
- Mitral valve prolapsed ☐
- Bronchitis ☐
- Gallbladder disease ☐
- Anesthetic complication ☐
- Mononucleosis ☐
- Bleeding disorder ☐
- Problems with anesthesia ☐
- Hives ☐
- Chest pain ☐
- Weight gain/loss ☐
- Mastitis ☐
- Ovarian cancer ☐

Previous Surgeries

Procedure	Date	Indication	Outcome

Please list all drugs (prescription and OTC), herbs and supplements that you take on a regular basis

Name	Dose

Family Medical History

Is there any family history of any of these conditions?

Condition	Yes	No	Comment
Diabetes			
Heart Disease			
High blood pressure			
Kidney disease			
Multiple births			
Mental retardation			
Birth defects			
Inherited diseases			
Rheumatoid arthritis			
Mental Illness			
Cystic fibrosis			
Allergies			
Drug abuse			
Thyroid disease			
Lupus erythematosis			
Blood disorders			
Breast cancer			
Ovarian cancer			

Cancer (other types)			
Sickle cell disease			
Tay Sachs			
Thalassemia			
Other			

Living?	Age or age of death	Health problems	Fertility problems
Mother			
Father			
Sister(s)			
Brother(s)			

Other history

What type of excercise do you do?______________________________

Do you smoke cigarettes? ______________________________

Do you smoke marijuana? ______________________________

Do you drink alcohol? ______________________________

How much caffeine do you drink per day (coffee, soda, tea,) __________________

How much water do you drink? ______________________________

Other drugs? ______________________________

Do you crave salty, fatty, spicy, or sweet foods? ________________________

Do you eat a lot of junk food? ______________________________

How many hours of sleep do you get per night? ________________________

Fertility history

How long have you been trying to conceive? ______________________________

Have you had any of the following tests done? ______________________________

Test	When	Results
FSH		
LH		
Estrodial		
Prolactin		
Progesterone		
Testosterone		
DHEA-S		
HIV		
TSH		
Endometrial biopsy		
Hysterosalpingogram		
Sonohystogram		

Have you done any clomid cycles? ______________________________

With ultrasound monitoring? ______________________________

With Hcg stimulation? ______________________________

With IUI? ______________________________

How did you feel when you did clomid? ______________________________

Have you done any injectable cycles (Follistim)? ______________________________

Have you done any IVF cycles? ______________________________

How many cycles have you done? ______________________________

How did you feel during your cycle? ______________________________

How many follicles did you produce? ______________________________

How many oocytes fertilized? ______________________________

Was ICIS used to fertilize? ______________________________

Male History

Has your partner been evaluated for fertility issue		Yes / No
Has your partner had a semen analysis		Yes / No
Result	Dare	
	Count (Million cell/ml)	
	Motility (%)	
	Morphology(%normal forms	
Has he been evaluated by an urologist?		