Acupuncture - Fertility Intake Form

Today's date_____

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?_____

Depending of where you are in your journey to conception some of the questions on this form may not apply to you. Just answer those that are relevant. Thank you!

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:

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

Family History:

❑ Alcoholism	❑ Fertility Issues
❑ Autoimmune Diseases	❑ Hysterectomy
❑ Breast Cancers	❑ Ovarian Cancers
❑ DES Usage	❑ Osteoporosis
❑ Diabetes	❑ Other Cancers _____
❑ Endometriosis/ Fibroids	❑ 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?	□ <3 days □ 3-6 days □>6 days
How is your overall flow?	□ Light □ Moderate □ Heavy
How is your clotting during menstruation?	□ None □ Few □ Moderate
How would you rate the size of your clots?	□ Small □ Medium □ Large
How are your menstrual cramps?	□ None □ Moderate □ Severe
How long do your cramps last?	□ Hours □ 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.)

❑ Stimulated cycle w/out IUI _____	❑ ZIFT _____
❑ Stimulated IUI _____	❑ IVF _____
❑ Non- Stimulated IUI _____	❑ IVF/ Donor _____
❑ GIFT _____	

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
□ Drugs
□ Regular Exercise:

□ Marijuana
□ Stress
□ Occupational Hazards

- Type_____ Frequency:_____

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