

Women's Fertility History

Name _____ Date _____

Age of menarche: _____ Date of last menses: _____ Cycle length: _____

Painful periods? No Yes How many days does the pain last? _____

of days of bleeding: _____ Flow strength: Light Normal Heavy

Color of blood? Light Red Red Dark Red Purple Brown Black

Are your cycles: Regular (i.e. every 28-30 days) Irregular, please explain:

Spot between periods? No Yes – every month? No Yes

Do you experience PMS? No Yes: Breast Tenderness Irritability Emotional Bloating
 Low Back Pain Loose Stools Constipation Nausea Headaches

Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Children _____

Have you had a D& C: No Yes – how many times? _____

Date of last Pap Smear: _____ Abnormal Pap Smear? Present Past

Have you ever had: Cervical Biopsy Cauterization Conization Operation

Venereal Disease? No Yes - HPV Herpes Other: _____

Vaginal Discharge? No Yes - Clear White Yellow Pink Brown Copious
 with ovulation only Chronic

Vaginal dryness? No Yes – have you been diagnosed with Vulvodynia? No Yes

Yeast Infections? No Yes - Every once in awhile Frequently Every month

Have you been diagnosis with: PID Uterine Fibroids Polyps Pelvic Adhesions Endometriosis
 Other : _____

Do you experience pain with intercourse? No Yes - sometimes every time

Do you find it difficult to achieve an orgasm? No Yes - sometimes every time

Is your libido: Low Average High

Do you ovulate? No Yes – what day of your cycle? _____

Have you used Clomid? Past Present

How are you tracking your ovulation? Ovulation test kits Basl Body Temps Cervical Fluid
 Fertility testing Other: _____

Have your menstrual cycles changes since they first began? No Yes – Please explain:

How long has you been trying to conceive? _____ Months Years

Have you received a Western Medical diagnosis? No Yes, please explain: _____

Are you currently under the care of a fertility clinic? No Yes, please name physician and clinic:

Have you or are you currently or do you plan to have fertility treatments? No Yes, please list any past, current or future treatments and dates: _____

Please indicate any tests you have completed and dates (or approximate month and year):

Test	Result	Date
Progesterone		
Estrogen		
FSH		
HSG		
Thyroid		

Surgeries/Procedures:

Please list any gynecological surgeries or procedures:

Procedure:	Reason for:	Date performed:

Medications:

Please list past medications used specifically for gynecological conditions, including contraceptives: (please list any medications for infertility purposes in the next section)

Medication:	Prescribed for:	Dates used:

Please list medication used specifically for fertility treatments:

Medication:	Prescribed for:	Dates used:

Have you ever had an IUD? No Yes, currently Yes, in past from _____ to _____

Have you ever taken Depo Provera? No Yes – when? _____

I understand that I am providing details of my fertility history to Red Peony Acupuncture, Inc. for informational purposes only. Licensed Acupuncturists are not Primary Care Physicians and while Acupuncture supports the fertility process, it does not replace standard medical care. Acupuncture has been well documented to increase and assist couples with their fertility process and I have provided complete and accurate information to Red Peony Acupuncture, Inc. so that the practitioners can provide the best care possible.

Signature _____ Date _____