



# Patient Information

## Fertility

Today's Date: \_\_\_\_\_

**Important:** The information on this form will help your doctor 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 the diagnosis and treatment of your problem.

<b>Number of:</b> Pregnancies: _____ Cesarean Births: _____ Vaginal Births: _____ Abortions: _____ Miscarriages: _____ Ectopic(s): _____ Failed IUI's: _____ Failed IVF's: _____	<b>General Patient Information</b> <i>All information is strictly confidential</i> Last Name: _____ First: _____ Middle Initial: _____ Age: _____ Cell Number: _____ Alternative Number: _____ Date of Birth: _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____ Occupation: _____ Employer: _____ Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered Spouse's Name: _____ Spouse's Age: _____ Has your husband/partner had a semen analysis? _____ Results: _____ Emergency Contact: _____ How did you hear about us? _____ What service(s) are you interested in?(check any that apply): <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage <input type="checkbox"/> Nutrition <b>Name of your:</b> Ob/Gyn: _____ Reproductive Endocrinologist: _____ Midwife: _____
Previous Gynecological Surgeries (check all that applies) <input type="checkbox"/> Dilation & Curettage(D&C) <input type="checkbox"/> Fallopscopy <input type="checkbox"/> (HSG) Hysterosalpingogram <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> Laparoscopy (endometriosis) <input type="checkbox"/> Laparoscopy (ovarian cysts) <input type="checkbox"/> Laparoscopy (uterine fibroids) <input type="checkbox"/> Mymectomy <input type="checkbox"/> Neosalpingostomy <input type="checkbox"/> Tuboplasty <input type="checkbox"/> Other: _____	

**Menstrual Cycle**

Age menstruation began: \_\_\_\_\_

How long have you been trying to get pregnant?: \_\_\_\_\_

(Please circle one) My periods are:

- A. Like clockwork
- B. Somewhat regular
- C. Erratic

Number of days in a typical 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 clear, stretchy and abundant?

- Yes  No

If not all three of these, describe:

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

Circle which PMS symptoms you get:

Breast Tenderness-Diarrhea-Acne

Bloating-Constipation-Back Pain

Food Cravings-Dizziness-Fatigue

Headache/Migraine-Mood Swings

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

- |  |   |
|--|---|
| <input type="checkbox"/> Advanced Maternal Age                 | <input type="checkbox"/> Luteal Phase Defect                      |
| <input type="checkbox"/> Amenorrhea                            | <input type="checkbox"/> Menorrhagia                              |
| <input type="checkbox"/> Anovulation                           | <input type="checkbox"/> Ovarian Cyst (single)                    |
| <input type="checkbox"/> Anti-sperm Antibodies                 | <input type="checkbox"/> Ovarian Cyst (multiple)                  |
| <input type="checkbox"/> Autoimmune Oopharitis                 | <input type="checkbox"/> Ovarian Hyperstimulation Syndrome (OHSS) |
| <input type="checkbox"/> Cervical Stenosis                     | <input type="checkbox"/> Pelvic Inflammatory Disease (PID)        |
| <input type="checkbox"/> Clotting w/ Period _____              | <input type="checkbox"/> Phospholipid Antibodies                  |
| <input type="checkbox"/> Delayed Cycles ___-___ Days           | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)       |
| <input type="checkbox"/> Menstrual Pain (mild)                 | <input type="checkbox"/> Premature Menopause                      |
| <input type="checkbox"/> Menstrual Pain (moderate)             | <input type="checkbox"/> Premature Ovarian Failure (POF)          |
| <input type="checkbox"/> Menstrual Pain (severe)               | <input type="checkbox"/> Resistant ovarian Syndrome               |
| <input type="checkbox"/> Elevated FSH _____                    | <input type="checkbox"/> Short Cycles ___-___ Days                |
| <input type="checkbox"/> Endometriosis(mild, moderate, severe) | <input type="checkbox"/> Spotting between periods ___-___ Days    |
| <input type="checkbox"/> Erratic Cycles ___-___ Days           | <input type="checkbox"/> Unexplained Infertility                  |
| <input type="checkbox"/> Fallopian Tube Blockage               | <input type="checkbox"/> Uterine Fibroids                         |
| <input type="checkbox"/> Habitual Miscarriage                  | <input type="checkbox"/> Uterine Septum                           |
| <input type="checkbox"/> Hostile Cervical Mucus                | <input type="checkbox"/> Others: _____                            |
| <input type="checkbox"/> Hyperprolactinemia                    |   |

List the Fertility Drugs you have taken: \_\_\_\_\_

Medications you use currently: \_\_\_\_\_

Have you been tested for Chlamydia?  Yes  No—Results:  Positive  Negative

**Medical Conditions and History (Check all that applies past/present)**

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Vein Condition         |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Mumps                  |
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Chicken Pox            |
| <input type="checkbox"/> Syphilis      | <input type="checkbox"/> Polio                  |
| <input type="checkbox"/> Meningitis    | <input type="checkbox"/> Migraines              |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver Disease          |
| <input type="checkbox"/> Paralysis     | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Thyroid Disorder       |
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Bleeding or Hemorrhage |
| <input type="checkbox"/> Pneumonia     | <input type="checkbox"/> Nervous Disorder       |
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Auto Immune Disease    |
| <input type="checkbox"/> HIV           | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> High Fever    | <input type="checkbox"/> Mental Illness         |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Chlamydia     | <input type="checkbox"/> Irregular Pap Smear    |
| <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Other: _____           |

**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 to let us know about?

\_\_\_\_\_  
\_\_\_\_\_



## Check YES or NO to each of the following questions

### (Ki-Yi)

- Do you have lower back weakness, soreness, pain, or knee problems?  Yes  No
- Do you have ringing in your ears or dizziness?  Yes  No
- Does your hair prematurely gray?  Yes  No
- Do you have vaginal dryness?  Yes  No
- Is your midcycle fertile cervical mucus scanty or missing?  Yes  No
- Do you have dark circles around or under your eyes?  Yes  No
- Do you have night sweats?  Yes  No
- Are you prone to hot flashes?  Yes  No
- Would you describe yourself as afraid a lot?  Yes  No
- Does your tongue lack coating? Does it appear shiny or peeled?  Yes  No

### (Ki Yan-)

- Do you have lower back pain premenstrually?  Yes  No
- Is your low back sore or weak?  Yes  No
- Are your feet cold, especially at nights?  Yes  No
- Are you typically colder than those around you?  Yes  No
- Is your libido low?  Yes  No
- Are you often fearful?  Yes  No
- Do you wake up at night or early in the morning because you have to urinate?  Yes  No
- Do you urinate frequently, and is the urine diluted and/or profuse?  Yes  No
- Do you have profuse vaginal discharge?  Yes  No
- Do you have early morning loose, urgent stools?  Yes  No
- Does your menstrual blood tend to be dull in color?  Yes  No
- Do you feel cold cramps during your period that respond to a heating pad?  Yes  No
- Is your tongue pale, moist, and swollen?  Yes  No

### (Sp-)

- Are you often fatigued?  Yes  No
- Do you have poor appetite?  Yes  No
- Is your energy low after a meal?  Yes  No
- Do you feel bloated after eating?  Yes  No
- Do you crave sweets?  Yes  No
- Do you have loose stools, abdominal pain, or digestive problems?  Yes  No
- Are your hands and feet cold?  Yes  No
- Is your nose cold?  Yes  No
- Are you prone to feeling heavy or sluggish?  Yes  No
- Are you prone to feeling heaviness or grogginess in the head?  Yes  No
- Do you bruise easily?  Yes  No
- Do you think you have poor circulation?  Yes  No
- Do you have varicose veins?  Yes  No
- Are you lacking strength in your arms and legs?  Yes  No
- Are you lacking in exercise?  Yes  No
- Are you prone to worry?  Yes  No
- Have you been diagnosed with low blood pressure?  Yes  No
- Do you sweat a lot without exerting yourself?  Yes  No
- Do you feel dizzy or light-headed, or have visual changes when you stand up quickly?  Yes  No
- Is your menstruation thin, watery, profuse or pinkish in color?  Yes  No
- Do you ever spot a few days or more before your period comes?  Yes  No
- Have you ever been diagnosed with uterine prolapse?  Yes  No
- Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?  Yes  No
- Are you often sick, or do you have allergies?  Yes  No
- Have you been diagnosed with hyperthyroid or anemia?  Yes  No
- Do you have hemorrhoids or polyps?  Yes  No
- Does your tongue look swollen, with teeth marks on the sides?  Yes  No
- Do you have a pale, yellowish complexion?  Yes  No



<b>Continued, Answer YES or NO to the following questions</b>
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**(Bl-)**

- |  |  |
|--|--|
| Are your menses scanty and/or late?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have dry, flaky skin?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you prone to getting chapped lips?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your fingernails or toenails brittle?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you losing hair on your head (not in patches, all over)          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your hair brittle or dry?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have diminished nighttime vision?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you get dizzy or light-headed around your period?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your lips, the inner side of your lower eyelids, or tongue pale? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**(Bl X)**

- |   |  |
|---|--|
| Is your menstrual flow ever brown or black in color?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel midcycle pain around your ovaries?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have painful, unmovable breast lumps?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you experience periodic numbness of your hands and feet (especially at night)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have red hemangiomas (cherry red spots) on your skin?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your complexion appear dark and "sooty"?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have chronic hemorrhoids?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your menstrual blood contain clots?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been diagnosed with endometriosis or uterine fibroids?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your lower abdomen tender to palpation (resisting touch)?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Can you feel any abnormal lumps in your lower abdomen?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have piercing or stabbing menstrual cramps?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your tongue look dark?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have dark spots on your tongue?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are the veins beneath your tongue twisty and tortuous?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have dark spots in your eyes?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been diagnosed with any vascular abnormality or blood clotting disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**(Lv X)**

- |   |  |
|---|--|
| Are you prone to emotional depression?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you prone to anger/and or rage?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you become irritable premenstrually?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel bloated or irritable around ovulation?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does it feel as if your ovulation lasts longer than it should?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your breasts sensitive/sore at ovulation?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you experience nipple pain or discharge from your nipples?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a lot of premenstrual breast distension or pain?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been diagnosed with elevated prolactin levels?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you become bloated premenstrually?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your pupils usually dilated and large?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have difficulty falling asleep at night?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you experience heartburn or wake up with a bitter taste in your mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your menses painful?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel your menstrual cramps in the external genital area?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your tongue dark or purplish in color?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**(Ht-)**

- |   |  |
|---|--|
| Do you wake up early in the morning and have trouble getting back to sleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have heart palpitations, especially when anxious?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have nightmares?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you seem low in spirit or lacking in vitality?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you prone to agitation or extreme restlessness?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you fidget?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the tip of your tongue red?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is there a crack in the center of your tongue that extends to the tip?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you sweat excessively, especially on your chest?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**Continued, Answer YES or NO to the following questions****(^H)**

- Is your pulse rate rapid?  Yes  No
- Is your mouth and throat usually dry?  Yes  No
- Are you thirsty for cold drinks most of the time?  Yes  No
- Do you often feel warmer than those around you?  Yes  No
- Do you wake up sweating or have hot flashes?  Yes  No
- Do you break out with red acne? (especially premenstrually)  Yes  No
- Do you have a short menstrual cycle?  Yes  No
- Do you have vaginal irritation or rashes?  Yes  No

**(D)**

- Do you feel tired and sluggish after a meal?  Yes  No
- Do you have fibrocystic breasts?  Yes  No
- Do you have cystic or pustular acne?  Yes  No
- Do you have urgent, bright, or foul-smelling stools?  Yes  No
- Does your menstrual blood contain stringy tissue or mucus?  Yes  No
- Are you prone to yeast infections and vaginal itching?  Yes  No
- Do your joints ache, especially with movement?  Yes  No
- Are you overweight?  Yes  No
- Do you have a wet, slimy tongue?  Yes  No

