# Women's Health & Fertility Intake Form

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Name: _____ Date of Birth: _____ Date: _____

## Gynecological/Reproductive History

Attempting Pregnancy currently? ____☐____ If so, for how long?_____
Currently Pregnant? If so, how far along? _____ Currently breastfeeding? If so, how long?_____
Difficult Scanty or Painful Lactation: _____
Post-Partum Difficulties: _____
Describe: _____
Premature Deliveries: _____ Difficult Deliveries: _____
Describe: _____
Difficulties in Pregnancy? Describe: _____
_____
Age of first Menses: _____ What was it like for you? _____
Date of last Menses: _____ Recent Menstrual Changes? If so, what ? _____
How many days do you normally Bleed? _____ How many days between Periods? _____
How Heavy is the Bleeding? ☐Heavy ☐Averag ☐Light How many Pads/Tampons per day? _____
What Color is the Blood? ☐Pale ☐Red ☐Pink Red ☐Dark Red ☐Purple ☐Brown ☐Black
Is the Blood: ☐Watery ☐Clotted ☐Mucousy ☐Thick ☐Stringy ☐Have an Odor
Painful Periods? If so, how many days does pain last? _____ What makes the pain better?_____
Heaviness or Pressure in Pelvis with Periods? ☐Yes ☐No
Have you ever gone more than 2 months without getting your Period? When?_____
PMS: What symptoms? _____ When do they start?_____
Bleeding/Spotting between Periods? If yes, when in cycle?_____
Do you Ovulate Regularly? _____ If so, on what day of your cycle?_____ Is Ovulation Painful?_____
Do you Observe Cervical Mucus Changes with Ovulation? _____ Bleeding with Ovulation?_____
Do any of your symptoms seem to change or worsen around your Period? How? _____
Menopausal Symptoms:
Describe_____

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## Sleep

How long do you normally sleep? _____ hours per night
I have difficulties with (check all that apply): ____☐__ Falling asleep ____☐__ Staying asleep
_☐__ Dream-disturbed sleep
_☐__ Waking up at about _____ am/pm and not being able to fall back asleep

## Emotional Health

Have you ever been treated for a psychological concern? Yes☐ No☐
Have you experienced sexual or physical abuse? Yes☐ No☐
Have you ever been treated for substance abuse? Yes☐ No☐
Please rate your overall stress level: Low☐ Medium☐ High☐
Are you currently working with a counselor? If so, who? _____
If possible, please describe the most challenging emotion you experience: _____
When do you most often feel this emotion? _____
What experiences or activities bring you the most joy and nourishment? _____
_____
Do you have a spiritual practice? _____
What goals do you have for your acupuncture treatments? _____
_____
Comments- please describe anything else you would like to discuss. _____
_____

## Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to complete this form.

Fertility Clinic _____
Physician _____
**Western Medical Diagnosis (if any)**_____
_____
_____

**Western Diagnostic Tests & Hormone Panels** (include dates & results)

- ★ Hysterosalpingogram (HSG) _____
- ★ Endometrial Biopsy _____
- ★ Clomid Challenge test _____
- ★ Follicle Stimulating Hormone (FSH) _____
- ★ Luteinizing Hormone (LH)_____
- ★ Estradiol (estrogen) _____
- ★ Progesterone _____
- ★ Prolactin _____
- ★ Doppler ultrasound (blood flow) _____
- ★ Hysteroscopy/Saline Infused Sonogram_____
- ★ Any additional tests: Anti Mullerian Hormone_____

_____

**GYN related surgeries (dates & outcome):**

**A.R.T. History:**
**Intrauterine Insemination (IUI)** Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

**In Vitro Fertilization (IVF)** Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

**Male Factor** (please include dates, results and any applicable treatment)

- ★ Sperm Count (#/cc) _____
- ★ Sperm Motility (% moving) _____
- ★ Sperm Morphology _____
- ★ Sperm Rise ("swim up test") _____
- ★ Anti-sperm Antibodies _____
- ★ Varicocele (including surgery) _____
- ★ Sperm penetration assay (SPA) _____
- ★ Other male factor concerns _____

**Other Past Treatments** Please indicate any other forms of past treatment, both conventional and alternative.

**Do you have any other comments, concerns, or issues that you would like to discuss?**