SELBY ACUPUNCTURE

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Female Fertility Intake

Please fill out the form as completely as possible.

Date: _____ Name: _____ Nickname: _____
Date of Birth: _____ Relationship Status: ☐Married ☐Partnered ☐Single ☐Widowed ☐Divorced
Address: _____
(street) (apt #)
_____
(city) (state) (zip)
Main Contact Phone: _____ Secondary Phone: _____
Email: _____ May we include you on our email newsletter? ☐Y ☐N
Occupation: _____ Employer: _____ Hours/week _____
Emergency Contact: _____
(name) (relationship) (phone)
Primary Physician: _____
(name) (location) (phone)

Reason for visit: _____ Have you had acupuncture before? ☐Y ☐N
Western diagnosis: _____ Have you used Chinese herbal medicine? ☐Y ☐N
How long have you been trying to conceive? _____
Pregnancies (please provide dates): _____ Age of children: _____
Miscarriages (please provide dates & how many weeks pregnant): _____
Abortions (please provide dates): _____ # times D&C performed: _____

<u>Ovulation</u>
Do you experience pain around ovulation? ☐Y ☐N Do your breasts get tender around ovulation? ☐Y ☐N
Do you notice stretchy clear egg-white slippery cervical mucus around ovulation? ☐Y ☐N
Do you track your ovulation? ☐BBT ☐Ovulation sticks ☐Other: _____

<u>Premenstrual Syndrome</u>
Do you experience any of the below symptoms? If so, how may days before period? _____
☐Fluid Retention ☐Cravings ☐Fluctuating Emotions ☐Irritability ☐Depression
☐Fatigue ☐Breast Tenderness ☐Acne ☐Headaches ☐Other: _____

<u>Periods</u>
Date of last menstrual period: _____ # days of bleeding: _____
Cycle length (i.e. 26-30 days): _____ Age of first menses: _____
Describe your flow: ☐Heavy ☐Light ☐Average Blood consistency: ☐Watery ☐Thick ☐Average

During your period do you suffer from: (mark as appropriate)

☐ Cramping At what age did it begin? _____

☐ Severe ☐ Moderate ☐ Mild ☐ Before period ☐ After period ☐ During period

☐ Clotting

☐ Bright in Color ☐ Dark in Color Describe color: _____

☐ Before period ☐ After period ☐ During period

☐ Bleeding between periods If so, how may days? _____

Color: ☐ Bright red ☐ Dark red ☐ Brown ☐ Other: _____

☐ Spotting

Color: ☐ Bright red ☐ Dark red ☐ Brown ☐ Other: _____

☐ Before period ☐ After period

Date of last pap smear: _____ Have you ever had an abnormal pap smear? ☐ Y ☐ N

Have you been diagnosed with:

☐ STD ☐ Uterine Fibroids ☐ Pelvic adhesions ☐ Endometriosis ☐ PCOS ☐ Pelvic Inflammatory Disease

☐ Polyps ☐ Prolapsed uterus ☐ Unique shape of uterus ☐ Frequent bladder infections ☐ Breast Cysts

☐ Yeast Infection/Vaginitis ☐ Other: _____

Have you been evaluated by an OB/GYN for your fertility? ☐ Y ☐ N If yes, when? _____

Have you been evaluated by an RE for your fertility? ☐ Y ☐ N If yes, when? _____

Have you had your fallopian tubes evaluated? (HSG) ☐ Y ☐ N

Have you taken medication to help you ovulate? ☐ Y ☐ N What kind? _____ # of cycles? _____

Have you undergone assisted reproductive treatments? (IUI, IVF, ICSI, etc.) ☐ Y ☐ N

Month/Year	Treatment	Clinic	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Birth control history (type used, how long, when did you stop, why?):

_____

_____

_____

Do you have a pacemaker or bleeding condition? _____

Do you have any infectious disease? ☐ No ☐ Yes (please identify) _____

Please list all known food or drug allergies _____

Please list all medications (prescription and over the counter) you are currently taking _____

_____

_____

Hospitalizations and Surgeries

Reason	When

Personal History (Please indicate Self (X), Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF))

	AIDS/HIV		Alcoholism		Anemia		Anxiety
	Arthritis		Asthma/Hay Fever		Back pain		Bursitis
	Cancer		Chronic Pain Condition		Chronic Fatigue		Constipation
	Depression		Diabetes		Diverticulitis/IBS		Emphysema
	Food Allergies/Intolerance		Gastritis/Pancreatitis		Headaches		Heart Disease
	Hepatitis		Hypertension		Hypo/Hyperglycemia		Infertility
	Impotence		Insomnia		Liver/Gallbladder Disease		Lyme Disease
	Migraines		Neck Pain		Respiratory Allergies		Raynaud's Disease
	Seizures		Stroke		Thyroid Imbalance		

Do you participate in the following physical activities? If so, please indicate how often:

Yoga: _____ Running: _____ Fitness classes: _____

Gym: _____ Biking: _____ Swimming: _____

Walking: _____ Other: _____

How would you rate your daily stress levels? ☐Low ☐Medium ☐High

What do you do to alleviate stress in your daily life? _____

_____

Anything else we should know? _____

How did you hear about us? _____

Signature _____ Date _____