ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
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FOR STAFF: PATIENT SHOULD COMPLETE NEW PATIENT INTAKE FORM

Female Fertility History

Patient Name: _____ Age: _____ Date: _____

Name of fertility doctor/specialist: _____ Contact Number: _____ Start date: _____

FERTILITY

How long have you been trying to conceive: _____

Have you had any diagnosis relating to fertility: ❑ No ❑ Yes , Describe: _____

Have you had any fertility treatments: ❑ No ❑ Yes , When: _____

Type: _____

Physician: _____

Have you taken medications to aid in ovulation: ❑ No ❑ Yes , When: _____

How long: _____

Have you had any hormonal lab tests: ❑ No ❑ Yes , Results: _____

Have your fallopian tubes been evaluated: ❑ No ❑ Yes , Results: _____

Have you had any tubal, or other operations: ❑ No ❑ Yes

Have you had any other diagnostic procedures: ❑ No ❑ Yes Type: _____

MENSTRUAL HISTORY

At what age did you begin menstruating: _____

Have your cycles changed in any way over time: ❑ No ❑ Yes , Describe: _____

How many days do your periods usually last: _____ days

Are your periods hesitant to begin: ❑ No ❑ Yes

Do you have spotting or bleeding between cycles: ❑ No ❑ Yes , When: _____

How heavy is your menstrual bleeding: ❑ Heavy ❑ Medium ❑ Light

Is there any clotting, and if so, when during your cycle: ❑ No ❑ Yes , When: _____

What color is your bleeding at start: _____ middle: _____ end: _____

What consistency is your blood at start: _____ middle: _____ end: _____

Does your blood contain any stringy tissue or mucus: ❑ No ❑ Yes

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Is your menstrual cycle spaced regularly from one month to the next: ❑ No ❑ Yes

Have you ever charted your menstrual cycles: ❑ No ❑ Yes When: _____

How many days are between your periods: _____ days

When was your last period : Start: _____ End: _____ Was it normal for you: ❑ No ❑ Yes

MENSTRUAL SYMPTOMS

Are your periods painful or uncomfortable in any way: ❑ No ❑ Yes

What does the pain feel like: _____

During which phase of your cycle do you experience the discomfort: _____

How many days does the discomfort last: _____

Are your breasts tender before, during or after your period: ❑ Before ❑ During ❑ After

Does your face break out before, during or after your period: ❑ Before ❑ During ❑ After

Do you have bloating before, during or after your period: ❑ Before ❑ During ❑ After

Do you have loose stools before, during or after your period: ❑ Before ❑ During ❑ After

Do you have constipation before, during or after your period: ❑ Before ❑ During ❑ After

Do you have low back pain before, during or after your period: ❑ Before ❑ During ❑ After

Are you tired or fatigued during or after your period: ❑ Before ❑ During ❑ After

What emotional symptoms do you experience before, during or after your period: _____

Do you have any other symptoms related to your cycles: ❑ No ❑ Yes , Describe: _____

OVULATION

Do you ovulate on your own: ❑ No ❑ Yes

On what day of your cycle do you ovulate: _____ days

Do you experience ovarian pain during ovulation: ❑ No ❑ Yes

Are your breasts tender during ovulation: ❑ No ❑ Yes

Is your mid-cycle cervical mucus scanty or missing: ❑ No ❑ Yes

Are you fatigued or tired during ovulation: ❑ No ❑ Yes

Are you bloated around ovulation: ❑ No ❑ Yes

Are you irritable around ovulation: ❑ No ❑ Yes

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Do you feel as through your ovulation time lasts too long: ❑ No ❑ Yes

GYNECOLOGICAL HISTORY

Have you ever had an abnormal pap smear: ❑ No ❑ Yes, When: _____

Date of last pap smear: _____

Have you ever had pelvic inflammatory disease: ❑ No ❑ Yes, When: _____

Have you ever had a venereal disease: ❑ No ❑ Yes, When: _____

Have you ever been diagnosed with a chlamydial infection: ❑ No ❑ Yes, When: _____

Do you have any genital sores: ❑ No ❑ Yes

Do you have regular yeast infections: ❑ No ❑ Yes

Do you have chronic vaginal discharge: ❑ No ❑ Yes, Color: _____ Consistency: _____

Do you have vaginal dryness: ❑ No ❑ Yes

Do you have vaginal itching or rashes: ❑ No ❑ Yes

Have you ever been diagnosed with uterine fibroids or polyps: ❑ No ❑ Yes, When: _____

Have you ever been diagnosed with endometriosis: ❑ No ❑ Yes, When: _____

Have you ever been diagnosed with pelvic adhesions: ❑ No ❑ Yes, When: _____

Have you ever been diagnosed with pelvic abnormalities: ❑ No ❑ Yes, When: _____

Have you ever had a cervical biopsy, operation, conization or cauterization: ❑ No ❑ Yes When: _____

Do you have any breast lumps, masses or fibroids: ❑ No ❑ Yes

Do you have any discharge from your nipples: ❑ No ❑ Yes

Have you felt any lower abdominal hard or movable masses: ❑ No ❑ Yes

Have you had any other gynecological conditions: ❑ No ❑ Yes , Describe: _____

Have you taken any medications besides contraceptives or fertility drugs: ❑ No ❑ Yes When: _____

PREGNANCY HISTORY

Have you had any pregnancies: ❑ No ❑ Yes

If so, what was your pregnancy health like: _____

How many children do you have: _____

How many abortions have you had: _____ When: _____

How many miscarriages have you had: _____ When: _____

How many times has a D&C been preformed: _____ When: _____

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CONTRACEPTION

Are you currently using any form of contraception: ❑ No ❑ Yes, Type: _____

Have you taken oral contraceptives, and what type: ❑ No ❑ Yes, Type: _____

When: _____

Have you ever had an IUD: ❑ No ❑ Yes, When: _____

Have you ever taken DepoProvera: ❑ No ❑ Yes, When: _____

YOUR PARTNER

Do you have a partner with which you are trying to conceive: ❑ No ❑ Yes

Is your partner supportive of your desire to conceive: ❑ No ❑ Yes

Has your partner's fertility been evaluated: ❑ No ❑ Yes, Results: _____

How is your partner's sexual energy: ❑ Good ❑ Fair ❑ Low

Has your partner had any problems relating to his reproductive health: ❑ No ❑ Yes, Describe: _____

YOUR MOTHER'S HEALTH

What was your mother's age when she was pregnant with you: _____

Did she have a difficult pregnancy: ❑ No ❑ Yes, Results: _____

What was your mother's health like prior to and after your birth: _____

Was your mother exposed to DES while she was pregnant with you: ❑ No ❑ Yes

At what age did your mother begin menopause: _____

At what age did you mother begin menstruating: _____

OTHER COMMENTS

Is there anything else you would like to share, or any concerns you would like to express at this time: