CONFIDENTIAL

women's fertility history I

NAME (LAST, FIRST, MIDDLE)		DATE
WEIGHT	HEIGHT	AGE

AGE AT WHICH MENSES BEGAN	HAVE YOUR CYCLES CHANGED SINCE THEN? IF SO, HOW?

ARE YOUR PERIODS PAINFUL?	HOW LONG DOES THE PAIN LAST?	HOW MANY DAYS DO YOU NORMALLY BLEED?	HOW MANY DAYS BETWEEN YOUR PERIODS?	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR:

HOW HEAVY IS THE BLEEDING?
Fill in the chart.

HEAVY
NORMAL
LIGHT

1 2 3 4 5 6 7 8 9 10
DAY

WHAT COLOR IS THE BLOOD?
Fill in the chart.

LIGHT RED
RED
DARK RED
PURPLE
BROWN
BLACK

1 2 3 4 5 6 7 8 9 10
DAY

Please answer yes or no to best describe your current condition.	YES	NO
DO YOU EXPERIENCE CLOTTING?	☐	☐
DO YOU HAVE PREMENTRUAL TENSION / PMS?	☐	☐
DOES YOUR FACE BREAK OUT BEFORE OR DURING YOUR PERIOD?	☐	☐
ARE YOUR BREASTS TENDER PREMENSTRUALLY?	☐	☐
DO YOU BLEED OR SPOT BETWEEN PEIODS?	☐	☐
ARE YOUR MENSTRUAL CYCLES SPACED IRREGULARLY?	☐	☐
IF SO, PLEASE EXPLAIN: _____		
ARE YOUR BREASTS TENDER AT / DURING OVULATION?	☐	☐
DO YOU GET PREMENSTRUAL LOW BACK PAIN?	☐	☐
DO YOU EXPERIENCE LOOSE STOOLS AT THE BEGINNING OF YOUR PERIOD?	☐	☐

Please answer yes, no, or with the number of occurrences.	YOUR ANSWER	DATE OR YEARS	
HOW MANY PREGNANCIES HAVE YOU HAD?	_____	_____	
HOW MANY CHILDREN DO YOU HAVE?	_____	_____	
HOW MANY ABORTIONS HAVE YOU HAD?	_____	_____	
HOW MANY MISCARRAIGES HAVE YOU HAD?	_____	_____	
HOW MANY TIMES HAS A D&C BEEN PERFOMRED?	_____	_____	HOW LONG?
HAVE YOU EVER TAKEN ORAL CONTRACEPTIVES?	_____	_____	_____
HAVE YOU EVER TAKEN DEPOPROVERA?	_____	_____	_____
HAVE YOU EVER HAD AN IUD?	_____	_____	_____

CONFIDENTIAL

women's fertility history II

NAME (LAST, FIRST, MIDDLE)	DATE

Have you ever been diagnosed with or experienced the following?

Please provide the number of occurrences, years / dates they occurred when applicable and any additional information that would be beneficial to the physician in determining your treatment plan.

	YES	NO	NUMBER	DATES	ADDITIONAL NOTES / INFORMATION
ABNORMAL PAP SMEAR	☐	☐			
ENDOMETRIOSIS	☐	☐			
LOW FSH	☐	☐			
PCOS	☐	☐			
PELVIC ABNORMALITIES	☐	☐			
LOW IRON	☐	☐			
ANEMIA	☐	☐			
LOW PROGESTERONE	☐	☐			
LOW ESTROGEN	☐	☐			
PELVIC ADHESIONS	☐	☐			
PELVIC INFLAMMATORY DISEASE	☐	☐			
UTERINE FIBROIDS	☐	☐			
POLYPS	☐	☐			
CYSTS	☐	☐			
HEP C	☐	☐			
GENITAL HERPES	☐	☐			
EARLY MENOPAUSE	☐	☐			
CHLAMYDIAL INFECTION	☐	☐			
VENERAL DISEASE	☐	☐			
REGULAR / FREQUENT YEAST INFECTIONS *(provide number per year)*	☐	☐			
CHRONIC VAGINAL DISCHARGE	☐	☐			
SORES ON GENETALIA	☐	☐			
CERVICAL BIOPSY,OPERATION, CAUTERIZATION OR CONIZATION	☐	☐			

CONFIDENTIAL

women's fertility history III

NAME (LAST, FIRST, MIDDLE)	DATE

HOW LONG HAVE YOU BEEN TRYING TO CONCEIVE? _____

REPRODUCTIVE ENDOCRINOLOGIST'S NAME (IF APPLICABLE) _____

WHICH OFFICE LOCATION DO YOU SEE HIM/HER AT FOR REGULAR APPOINTMENTS? _____

	YES	NO	DATE	DESCRIPTION
HAVE YOU HAD A DIAGNOSIS RELATING TO INFERTILITY?	☐	☐	_____	_____
HAVE YOU HAD FERTIITY TREATMENTS?	☐	☐	_____	_____
HAVE YOUR FALLOPIAN TUBES BEEN MEDICALLY EVALUATED?	☐	☐	_____	_____
HAVE YOU HAD ANY TUBAL OPERATIONS?	☐	☐	_____	_____
HAVE YOU HAD HORMONE LABORATORY TESTS PERFORMED?	☐	☐	_____	_____
HAS YOUR PARTNER HAD A FERTILITY WORKUP?	☐	☐	_____	_____
DOES YOUR PARTNER HAVE A DIAGNOSIS RELATING TO INFERTILITY?	☐	☐	_____	_____
DO YOU OVULATE ON YOUR OWN? *(If yes, on what day of your cycle?)*	☐	☐	_____	_____
HAVE YOU TAKEN MEDICATION TO HELP YOU OVULATE?	☐	☐	_____	_____
HAVE YOU HAD ACUPUNCTURE FOR FETILTY? *(If yes, where?)*	☐	☐	_____	_____

Please list the results of the following below or attach copies of you lab reports to this packet.

MEDICAL EVALUATION OF FALLOPIAN TUBES

TUBAL OPERATIONS

HORMONE LABORATORY TESTS

CONFIDENTIAL

women's fertility history IV

NAME (LAST, FIRST, MIDDLE)	DATE

ARE YOU CURRENTLY TAKING OR HAVE YOU IN THE PAST TAKEN MEDICATION FOR TREATING INFERTILITY? ☐ YES ☐ NO

HAVE YOU EVER TAKEN / USED HERBS, SUPPLEMENTS, CREAMS, ETC TO ASSIST WITH FERTILITY? ☐ YES ☐ NO

IF YES, WHERE DID YOU LEARN OF THE ABOVE?

_____

DO YOU DOUCHE REGULARLY? ☐ YES ☐ NO

IF YES, WITH WHAT?

_____

DO YOU USE VAGINAL LUBRICANTS? ☐ YES ☐ NO

IF YES, WITH WHAT?

_____

ARE YOU MORE THAN 20% OVER YOUR IDEAL BODY WEIGHT? ☐ YES ☐ NO

ARE YOU MORE THAN 20% BELOW YOUR IDEAL BODY WEIGHT? ☐ YES ☐ NO

DO YOU HAVE A STRESSFUL OCCUPATION OR HOME LIFE? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU HAVE EXCESSIVE FACIAL HAIR? ☐ YES ☐ NO

DO YOU HAVE EXCESSIVELY OILY SKIN? ☐ YES ☐ NO

HAVE YOU EXPERIENCED EXCESSIVE LOSS OF HEAD HAIR? ☐ YES ☐ NO

HAVE YOU NOTICED DISCHARGE FROM YOUR NIPPLES? ☐ YES ☐ NO

WAS YOUR MOTHER EXPOSED TO DES WHEN SHE WAS PREGNANT WITH YOU? ☐ YES ☐ NO

HAVE YOU BEEN EXPOSED TO ANY KNOWN ENVIRONMENTAL TOXINS OR HORMONES? ☐ YES ☐ NO

ARE YOU PRESENTLY TAKING STEROIDS? ☐ YES ☐ NO

DO YOU HAVE A SINGLE PARTNER WITH WHOM YOU ARE TRYING TO CONCEIVE? ☐ YES ☐ NO

IS YOUR PARNTER SUPPORTIVE OF YOUR WISH TO CONCEIVE? ☐ YES ☐ NO

IS YOUR PARTNER TAKING / USING ANY MEDICATIONS, HERBS, SUPPLEMENTS, CREAMS, ETC. TO ASSIST WITH FERTILITY? ☐ YES ☐ NO

WHAT BOOKS HAVE YOU READ ON FERTILITY?

_____

_____

_____

HOW DID YOU LEARN ABOUT ACUPUNCTURE ASSITING FERTILITY?

_____

_____

_____

HOW WERE YOU REFERRED TO THE CAPORALE CENTER OF NATURAL MEDICINE?

_____

PLEASE LIST ANY MEDICATIONS, HERBS, SUPPLEMENTS OR CREAMS YOU ARE TAKING OR HAVE TAKEN TO ASSIST WITH FERTILITY.

NAME & STRENGTH	CURRENTLY TAKING?	TOTAL DAILY DOSAGE	DATES TAKEN

***List any additional on the reverse side of this page.*

PLEASE LIST ANY HERBS, SUPPLEMENTS OR CREAMS YOU ARE TAKING NOT RELATED TO A FERTILITY CONCERN.

NAME & STRENGTH	HOW LONG?	TOTAL DAILY DOSAGE	DATES TAKEN

***List any additional on the reverse side of this page.*

PLEASE LIST ANY MEDICATIONS, HERBS, SUPPLEMENTS OR CREAMS YOUR PARTNER IS CURRENTLY TAKING FOR ALL CONCERNS, INCLUDING FERTILITY.

NAME & STRENGTH	HOW LONG?	TOTAL DAILY DOSAGE	DATES TAKEN

***List any additional on the reverse side of this page.*

We invite you to share any additional information or concerns in regards to your fertility on a separate sheet of paper and attach it to this packet.