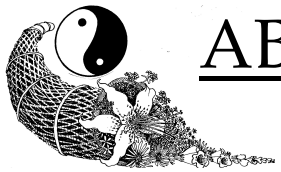

# ABUNDANCE ACUPUNCTURE, INC.

☯ W1185 McCrae Road, Fall River, WI 53932 (920) 484-5000 ☯

***"Realize the wonderful benefits of Oriental Medicine"***

## Women's Fertility History

**CONFIDENTIAL**

Were you given soy based formula as a baby? □ Yes □ No

Age at which menses began _____
Are your periods painful? □ Yes □ No
How many days does the pain last? _____
How many days do you normally bleed? _____
How heavy is the bleeding? □ Light □ Normal □ Heavy
What color is the blood? □ Light red □ Red □ Dark red □ Purple □ Brown □ Black

Is there clotting? □ Yes □ No
Do you have premenstrual tension? □ Yes □ No
Does your face break out before or during your period? □ Yes □ No

Do your breasts become tender premenstrually? □ Yes □ No
Do you bleed or spot between periods? □ Yes □ No
Are your menstrual cycles spaced irregularly? □ Yes □ No
How many days are there from one period to the next? _____

| | Number | Years |
|---|---|---|
| Date of last menstrual period | | |
| How many pregnancies have you had? | _____ | _____ |
| How many children do you have? | _____ | _____ |
| How many abortions have you had? | _____ | _____ |
| How many miscarriages have you had? | _____ | _____ |
| How many times has a D&C been performed? | _____ | _____ |

Have you ever had an abnormal pap smear? □ Yes □ No
Have you ever had a cervical biopsy, operation, cauterization or conization? □ Yes □ No

Have you ever had a venereal disease? □ Yes □ No
Do you get yeast infections regularly? □ Yes □ No
Have you ever been diagnosed with a Chlamydia infection? □ Yes □ No
Were you treated for it? □ Yes □ No
Do you have chronic vaginal discharge? □ Yes □ No
Do you have any sores on your genitalia? □ Yes □ No
Have you ever had pelvic inflammatory disease? □ Yes □ No

Date of last Pap smear _____
Have you ever been diagnosed with uterine fibroids or polyps? □ Yes □ No
Have you ever been diagnosed with endometriosis? □ Yes □ No
Have you been diagnosed with pelvic adhesions? □ Yes □ No
Have you been diagnosed with any pelvic abnormalities? □ Yes □ No

Have you taken any medications for gynecological conditions other than birth control? □ Yes □ No

| Medication | Reason | How long |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have your cycles changed since they began? □ Yes □ No
How? _____

_____

Do you ovulate on your own? □ Yes □ No
On what day of your cycle? _____
Do your breasts get tender at/during ovulation?
Do you get premenstrual low back pain? □ Yes □ No
Do your bowel movements become loose at the beginning of your period? □ Yes □ No

## Women's Fertility History *Continued*

Have you had fertility treatment? □Yes □ No
If yes, when and where? _____

By whom? _____

What type? _____

Have you taken medication to help you ovulate? □Yes □ No
When _____ How long? _____

Have your fallopian tubes been evaluated medically?
□Yes □ No
What were the results? _____

_____

Have you had any tubal operations? □Yes □ No
Have you had any hormone laboratory tests performed?
□Yes □ No What were the results? _____

_____

Do you have one partner with whom you have been trying to conceive? □Yes □ No

How long have you been married or living together? _____

_____

Has he had a fertility workup? □Yes □ No
What were the results? _____
Is your partner supportive of your wish to conceive? □Yes □ No

Have you taken oral contraceptives? □Yes □ No

When _____How long? _____

Have you ever had an IUD? □Yes □ No

When _____How long? _____

Have you ever taken DepoProvera? □Yes □ No

When _____How long? _____

How long have you been trying to conceive? _____
Have you had a diagnosis relating to infertility? □Yes □ No

What was it?_____

How is your sexual energy? □ Low □ Normal □ High
Do you douche regularly? □Yes □ No
With what? _____

Do you use vaginal lubricant ? □Yes □ No
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? □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 nipple? □Yes □ No

Was your mother exposed to diethylstilbestrol (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

COMMENTS/NOTES