Acupuncture Clinic of Boulder, Inc.®

2500 Arapahoe Avenue, Suite 290 | Boulder, CO 80302
p: 303-665-5515 | f: 303-665-5832 | acuboulder.com

Women's Fertility

Date:

Last name / First name / Circle: Miss Ms. Mrs. Dr.

Birth date /	Age /	Circle # of preferred contact
Address /		Phone (home) /
City /		Phone (work) /
Province /	Postal Code /	Phone (cell) /
Email /		Occupation /
Height /	Weight /	Emergency Contact /

Reason for Visit /

Have you had Acupuncture before? Yes No
Chinese herbal medicine? Yes No

Family Physician name /	Family Physician phone /
Western Medical diagnosis (if applicable) /	

Other medical treatment received (circle) / Fertility clinic Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

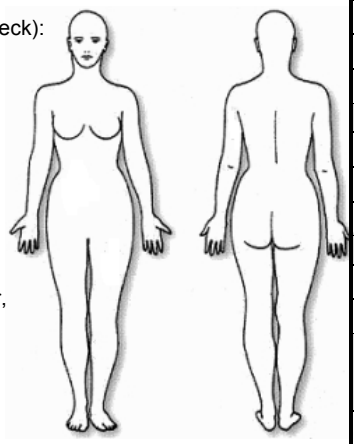
	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Haemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain ;

Sensations/pain characteristics (check):
Sharp __ Burning __ Moving __
Tingling __ Dull __ Severe __
Stabbing __ Shooting __
Throbbing __ Numbness __

What relieves the pain (ice, rest, activity, massage, heat…)?
_____
_____

What aggravates the pain (weather, heat, cold, rest, activity…)?
_____
_____



Please list any prescription medication or over the counter drugs currently taking:

1.	2.
3.	4.
5.	6.

Please list herbal medicine and other supplements currently taking:

1.	2.
3.	4.
5.	6.

Please list any allergies (food, drugs, environmental, etc.):

1.	2.
3.	4.

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop: _____

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Acupuncture Clinic of Boulder? (Internet, Friend, Doctor, Seminar, Magazine, TV, News, etc.) _____

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For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

Besides fertility, list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what you crave. (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Do you wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

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Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___ **Consistency of blood**: Watery ___ Thick ___ Average ___

Does your blood contain clots? Yes ___ No ___ …and... **At which point during the cycle?** Start ___ Mid ___ End ___

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During _____ (please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness ___ Cramps ___ Acne ___ Change in bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___
Fatigue ___ Night sweats ___ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? _____	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ How many times have you given birth? _____
Ages of children _____ Sex of children _____ Given names _____
Have you had any miscarriages? Yes ___ No ___
If yes, how many, at how many weeks pregnant, and in what year(s)?
_____
_
How many times have you had a D&C preformed? _____
How many abortions have you had? _____ In what year(s)? _____
Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:

STD? …….	Yes__ No__
Pelvic inflammatory disease? ……	Yes__ No__
Uterine fibroids? ……..	Yes__ No__
Polyps? ……	Yes__ No__
Pelvic adhesions? ……	Yes__ No__
Prolapsed uterus? ……	Yes__ No__
Unique shape of uterus?	Yes__ No__
Endometriosis? ……	Yes__ No__
PCOS (polycystic ovarian syndrome)? ……..	Yes__ No__

Date of last pap smear: _____/_____/_____ (dd/mm/yyyy)
Have you ever had an abnormal pap smear? Yes ___ No ___
Have you ever had a cervical biopsy or operation? Yes ___ No ___
Do you get yeast infections regularly? Yes ___ No ___
Do you get bladder infections regularly? Yes ___ No ___
If answered yes, list STDs: _____

Do you experience vaginal discharge? Yes ___ No ___
If yes, what colour?
White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odour? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ___
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes ___ No ___
Have you ever taken Depo-Provera? Yes ___ No ___

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Have you had any hormone testing done? (e.g., Day 3, Day 21)

FSH	___ Low	___ Normal	___ High
Estrogen (E2)	___ Low	___ Normal	___ High
Progesterone	___ Low	___ Normal	___ High
Prolactin	___ Low	___ Normal	___ High
Thyroid (TSH)	___ Low	___ Normal	___ High
Testosterone	___ Low	___ Normal	___ High
Other: _____	___ Low	___ Normal	___ High

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Do you currently have a partner? __ Yes __ No
If yes, what is your partner's name? _____ Age? _____
Are you married or living together? _____ For how long? _____
Is your partner supportive of your wishes to conceive?_____

How long have you been trying to conceive? _____

Do you have a family history of infertility (mother, father, grandparents, aunt, uncle, siblings)? _____
If yes, which family members?_____ Diagnosis?_____

Have you had a Western medical diagnosis relating for fertility? __ Yes __ No
If yes, what was the diagnosis? _____ Who made the diagnosis? _____

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Has your partner (if applicable) had a Western medical diagnosis relating to fertility? __ Yes __ No
If yes, what was the diagnosis? _____ Who made the diagnosis? _____

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Have you taken medication to help you ovulate? __ Yes __ No
If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? __ Yes __ No
What were the results? _____

Have you had any tubal operations? __ Yes __ No

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc) __ Yes __ No

Month/Year	Type of treatment	Clinic	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What was your medical response to the fertility treatments? ___ Poor ___ Average ___ Good

Are you using donor sperm? __ Yes __ No
If yes, why? (no partner, female partner, male partner has semen issues, etc.) _____

Are you using donor eggs or embryos? __ Yes __ No

How is your sexual desire (mental interest)?.....	___ Low	___ Normal	___ High
How is your sexual arousal (physical/orgasm)?.....	___ Low	___ Normal	___ High**!**
Do you use vaginal lubricants?.....	__ Yes	__ No	
Have you been exposed to or received chemotherapy or radiation? ...	__ Yes	__ No	
Do you have excessive facial or body hair?	__ Yes	__ No	
Do you have excessively oily skin?	__ Yes	__ No	