NATURAL HEALING & ACUPUNCTURE INC.
Acupuncture • Herbal Medicine • Nutrition • Massage NaturalHealingAcupuncture.com
2001 S. Barrington Ave. Suite 220, Los Angeles, CA 90025 P: 310-473-7474 F: 310-473-9767

Denise Wiesner, L.Ac.
Alex Berks, L.Ac.

Women's Fertility History

Name(Last, First, middle)	Date

1. Menstrual cycle

How long does your period last? _____
Date of last menstrual period?_____
How many days between cycles? _____
Are your periods irregular? Please explain_____
_____
How many days are there from one period to next _____
How heavy is the bleeding? light ☐ normal ☐ heavy ☐
What color is the blood? Normal red ☐ Light red ☐ dark red ☐ purple ☐ brown ☐ black ☐
Is there clotting? Yes ☐ No ☐
Age at which menses began _____
Have cycles changed since they began_____
_____
If you ovulate, what day of the cycle? _____

2. Pre-menstrual issues

Check if you have any of the following:

- ☐ PMS symptoms
- ☐ Sore/tender breasts?
- ☐ acne breakouts?
- ☐ Irritable, depressed?
- ☐ Low back pain? (circle one) before ☐ during ☐ after cycle ☐
- ☐ Loose stools? (circle one) before ☐ during ☐ after cycle ☐
- ☐ Headaches? (circle one) before ☐ during ☐ after cycle ☐

Other _____

3. Gynecology History

Have you ever had any of the following procedures: (please check box)
Abnormal Pap smear, cervical biopsy, cervical operation, cauterization, conization?
When? _____ ☐ ☐ ☐ ☐ ☐

Date of last Pap smear? _____
Other gynecological procedures? _____
Gynecology surgeries? _____

Have you ever had any of the following?

- ☐ Yeast infections regularly
- ☐ Chronic vaginal discharge
- ☐ Painful Intercourse

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Have you ever been diagnosed with any of the following:

- ☐ Endometriosis
- ☐ HPV (human papiloma virus)
- ☐ Venereal disease
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Uterine fibroids or polyps
- ☐ Pelvic adhesions
- ☐ Pelvic inflammatory disease

If yes to any of the above, when were you treated?_____
How were you treated? _____

	How many	Year
Pregnancy	_____	_____
Children	_____	_____
Abortions	_____	_____
Miscarriages	_____	_____
D&C's	_____	_____

Have you taken oral contraceptives? When? _____ How long? _____
☐ Do you use an IUD?

4. Fertility Treatment History

How long have you been trying to conceive? _____
Do you have a diagnosis related to infertility? _____
Have you had fertility treatments? Please explain when and by whom? (use another sheet if necessary)

Have you had a fallopian tube evaluation? Yes ☐
Have you had other functional tests? _____
What were the results? _____
What hormonal laboratory tests were performed?_____
What were the results? _____

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Please list any and all medications you are currently taking?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Lifestyle

How is your sexual energy? (check a box) Low ☐ normal ☐ high ☐

- ☐ Do you douche?
- ☐ Do you use vaginal lubricants?
- ☐ Do you have a stressful occupation?
- ☐ Do you exercise regularly?
  - What do you do and how often? _____
- ☐ Do you have excessive facial hair ?
- ☐ Excessive loss of head hair?
- ☐ Discharge from nipples?

What is your height? _____and weight _____

- ☐ Was your mother exposed to DES (diethylstilbestrol) when she was pregnant?
- ☐ Have you been exposed to any known environmental toxins or hormones?

_____