point flow acupuncture

NEW PATIENT FERTILITY HISTORY

REFERRED BY: _____

1. IDENTIFYING INFORMATION

Date _____/_____/_____

Name _____ DOB _____/_____/_____ Age _____

Significant Other Name _____ DOB _____/_____/_____ Age _____

Address _____ City _____ State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Primary Gyn MD _____ Phone _____

Primary RE MD _____ Phone _____

How long have you been attempting conception?_____ Marital Status_____

Western Diagnosis: _____

2. RACE (You)

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

ETHNICITY
❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

Significant Other

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

3. PREGNANCY HISTORY

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____ Elective abortion _____ Adopted children ____

	Date	Miscarriage	Elective Abortion	Ectopic	Months to conceive?	Infertility Treatment	Weigh and Sex?	C-section?	Complications?	Is current Partner the father?
1.										
2.										
3.										
4.										

4. CONTRACEPTIVE USE

	Type	From when to when	Reason discontinued
1.			
2.			
3.			

5. OPERATIONS AND HOSPITALIZATIONS

	Date	Diagnosis	Operation	Where	Physician
1.					
2.					
3.					

6. **MEDICATIONS** *List all prescriptions and over-the-counter drugs used during the past year*

	Date	Name	From when to when	Reason discontinued
1.				
2.				
3.				

7. ALLERGIES

	Drug or substance	When	Reaction
1.			
2.			

8. MENSTRUAL/HORMONAL

Height _____ Weight _____ Blood Type (if known) _____

Age at first period ..... Date of last two menstrual periods _____/_____/_____ and _____/_____/_____

Are your periods regular? ❑ yes ❑ no Do you bleed between periods? ❑ yes ❑ no

How many days from onset to onset? ..... What is the usual duration of your periods? .....days

Premenstrual symptoms occur: ❑ almost always ❑ rarely ❑ never

Vigorous exercise: type ..... hrs/week ..... type ..... hrs/week.....

If you have a hormonal disorder, please specify type and treatment: .....

Last pap smear _____/_____/_____

***Pelvic pain/cramps**:* ❑ none ❑ during menses ❑ before menses ❑ after menses ❑ at midcycle ❑ during intercourse ❑ with bowel movements ❑ with urination ❑ cause you to miss work ❑ cause you to miss usual activities

Pelvic pain/cramps are: ❑ mild ❑ moderate ❑ severe ❑ worsening ❑ improving ❑ no change ❑ in midline ❑ on right side ❑ on left side

Frequency of intercourse _____

Do you have or have you had? (Check all that apply).

- ❑ Hot flushes
- ❑ Breast discharge
- ❑ Visual disturbance
- ❑ Poor sense of smell
- ❑ Chronic headache
- ❑ Head trauma
- ❑ Increased facial or body hair
- ❑ Increased acne
- ❑ Weight increase > 10 pounds
- ❑ Weight loss > 10 pounds
- ❑ Special dietary habits
- ❑ Vomiting
- ❑ Seizures
- ❑ Diabetes
- ❑ Thyroid disorder
- ❑ Autoimmune disease
- ❑ Extraordinary stress
- ❑ Psychiatric treatment

Please explain a "Yes" answer: _____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

- ❑ Pelvic infection
- ❑ Chlamydia
- ❑ Endometriosis
- ❑ Pelvic adhesions
- ❑ Cervicitis
- ❑ Genital herpes
- ❑ Appendicitis
- ❑ Colitis or enteritis
- ❑ Uterine fibroids or myomas
- ❑ Abnormal uterus shape
- ❑ Recurrent vaginitis
- ❑ Abnormal Pap smears
- ❑ Gonorrhea
- ❑ Syphili
- ❑ Mycoplasma
- ❑ Ureaplasma
- ❑ Genital warts / condyloma
- ❑ Cryo (freezing) or surgery of the cervix
- ❑ Ovarian cysts
- ❑ Toxoplasmosis
- ❑ Cytomegalovirus (CMV)
- ❑ Tuberculosis
- ❑ Trichomonas

10. OTHER HISTORY

Your occupation: ..... Spouse's occupation: ……

Cigarettes - packs smoked per day:.....

Alcohol - type and number per week:…….....

Marijuana - amount: .....…

Other drugs - type and amount: .....…

Caffeine drinks per day: .....…

Video display terminal hours / day: .....

Electric blanket use: ❑ yes ❑ no Toxic exposure: ❑ yes ❑ no Ever used intravenous drugs? ❑ yes ❑ no

Hot tub or sauna use: ❑ yes ❑ no Radiation exposure: ❑ yes ❑ no

11. MEDICAL ILLNESSES

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Colitis / enteritis
- ❑ Blood transfusion
- ❑ Recent immunization

Please explain a "Yes" answer to any of the above:……
……
……

12. FAMILY HISTORY

	Age or living?	age at death	Health Problems
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			

Which of your blood relatives have?

Cancer .....
Venous Thrombosis (blood clotting)……
Diabetes .....
Hypertension .....
High Cholesterol .....
Heart disease .....
Stroke .....
Premature menopause .....
Endometriosis .....

Uterine fibroids (myomas) .....

13. GENETIC HISTORY Do you, your partner, or anyone in either family have?

- ❑ Neural tube defects/ spina bifida/anencephaly
- ❑ Thalassemia
- ❑ Down syndrome
- ❑ Cystic fibrosis
- ❑ Muscular dystrophy
- ❑ Huntington chorea
- ❑ Mental retardation / fragileX
- ❑ Tay-Sachs disease
- ❑ Sickle cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal disorder
- ❑ Any inherited disorders?
- ❑ Chromosomal disorder
- ❑ Genetic / inherited disorder
- ❑ Baby with birth defects
- ❑ Infertility

Please explain a "Yes" answer to any of the above:……

14. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____ ❑ mild ❑ moderate ❑ severe
❑ improving ❑ worsening ❑ no change ❑ with visual symptoms ❑ with vomiting ❑ stress related ❑ migraines

- ❑ Wear glasses
- ❑ Wear contact lenses
- ❑ Sinus problems
- ❑ Hayfever
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Denture / bridges
- ❑ Chronic constipation
- ❑ Diarrhea
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting spells
- ❑ Leg swelling
- ❑ Calf pain
- ❑ Blood clots (venous thromboembolism)
- ❑ Breast mass
- ❑ Breast implants
- ❑ Do monthly breast self-exam
- ❑ Bladder/kidney infections
- ❑ Urgent / frequent / painful urination
- ❑ Blood / abnormal color of urine
- ❑ Unable to control urination
- ❑ Abnormal urinary tract
- ❑ Kidney x-ray
- ❑ Bladder cystoscopy
- ❑ Recent stress increase
- ❑ Recent anxiety increase
- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ Bleeding from gums
- ❑ Nosebleeds
- ❑ Take aspirin/ibuprofen frequently
- ❑ Arthritis
- ❑ Back pain
- ❑ Shortness of breath
- ❑ Cough up blood
- ❑ Abdominal pain
- ❑ Nausea and vomiting
- ❑ Vomiting blood
- ❑ Ulcer
- ❑ Food intolerance
- ❑ Gallstones
- ❑ Jaundice / hepatitis
- ❑ Anemia
- ❑ Blood in bowel movement
- ❑ Irritable bowel
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Abnormal liver test
- ❑ Unusual hair loss
- ❑ Extraordinary fatigue
- ❑ Fibrocystic changes
- ❑ Mammogram
- ❑ TB skin test
- ❑ Acne
- ❑ Skin disorder
- ❑ Rash
- ❑ Hives
- ❑ Skin cancer
- ❑ Counseling
- ❑ Varicose veins
- ❑ Sensation loss / numbness
- ❑ Muscle control / weakness
- ❑ Heat or cold intolerance
- ❑ Damp skin
- ❑ Cough
- ❑ Wheezing
- ❑ Chest x-ray

OTHER:_____

15. MALE HISTORY:

❑ Medications: ❑ Reproductive surgery: ❑ Illnesses: ❑ STDs: ❑ Mumps: ❑ Testicular trauma:
❑ Smoker: ❑ Impotence: ❑ Alcohol: ❑ Allergies: ❑ Ejaculatory Disorder:
Have you seen a urologist for infertility? ❑ Yes ❑ No

If yes: Physician name and location ……..
Have you ever fathered a child/pregnancy with another woman? ❑ Yes ❑ No
If yes, when? …….. years ago

Have you ever been diagnosed with an infertility diagnosis except for currently? ❑ Yes ❑ No
If yes, when? …….. years ago
Comments:_____
_____

16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? ❑ yes ❑ no

If yes, who was your physician? ……
……..
What cause of infertility was diagnosed? ……
……

What drugs have you taken for infertility? Please check all that apply:

- ❑ Clomid (Serophene)
- ❑ Gonal F
- ❑ Follistim
- ❑ Repronex
- ❑ Pergonal
- ❑ Fertinex
- ❑ hCG Profasi
- ❑ Progesterone
- ❑ Lupron
- ❑ Microdose Lupron
- ❑ Antagon
- ❑ Parlodel
- ❑ Antibiotics
- ❑ Baby aspirin
- ❑ Heparin
- ❑ Steroids
- ❑ Oral Contraceptives
- ❑ Other ……

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ BBT	When _____/_____/_____	Results ……
❑ Postcoital Test	When _____/_____/_____	Results ……
❑ Hormonal Assays (FSH, LH, Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone)	When _____/_____/_____	Results ……
❑ Endometrial biopsy	When _____/_____/_____	Results ……
❑ Hysterosalpingogram	When _____/_____/_____	Results ……
❑ Sonohystogram	When _____/_____/_____	Results ……
❑ Ultrasound	When _____/_____/_____	Results ……
❑ Laparoscopy, Hysteroscopy	When _____/_____/_____	Results ……
❑ Mycoplasma culture	When _____/_____/_____	Results ……
❑ Chlamydia culture	When _____/_____/_____	Results ……
❑ GC Culture	When _____/_____/_____	Results ……
❑ Thyroid tests	When _____/_____/_____	Results ……
❑ Rubella (German measles)	When _____/_____/_____	Results ……
❑ Varicella (Chicken pox)	When _____/_____/_____	Results ……
❑ Cytomegalovirus (CMV)	When _____/_____/_____	Results ……
❑ Antibody screen	When _____/_____/_____	Results ……
❑ Blood type	When _____/_____/_____	Results ……
❑ Chromosomes	When _____/_____/_____	Results ……
❑ Genetic screening	When _____/_____/_____	Results ……
❑ Hepatitis B	When _____/_____/_____	Results ……
❑ Hepatitis C	When _____/_____/_____	Results ……
❑ HIV	When _____/_____/_____	Results ……
❑ HTLV	When _____/_____/_____	Results ……
❑ RPR (Serology)	When _____/_____/_____	Results ……
❑ Semen analysis	When _____/_____/_____	Results ……
❑ Antisperm antibodies	When _____/_____/_____	Results ……
❑ Varicocele repair	When _____/_____/_____	Results ……
❑ Testicular biopsy	When _____/_____/_____	Results ……

❑ OTHER: ……

Have you done any Clomid cycles? _____ Did you produce any follicles? _____

How thick did your endometrium get ? _____ Did you get any side effects, such as mood swings? _____

Have you done Artificial Insemination (IUI) _____

Have you ever undergone or In Vitro Fertilization (IVF)? ❑ yes ❑ no

If yes, ❑ partner ❑ donor sperm

Date of IVF	How many follicles did you produce	How many eggs were retrieved	How many eggs fertilized?	How thick was your endometrium at time of retrieval?