Infertility and Woman's Health History Form

Name: _____ Date of First Office Visit _____

Present Age _____ Present Weight _____ Height_____

Menstrual History

Age at which menses began _____ Date of last menstrual period _____

Length of menstrual cycle ___days (from 1st day of bleeding until the day before the next bleeding)

Are your menstrual cycles spaced irregularly? __ Yes __ No

How many days do you bleed? _____ How heavy is the bleeding? __Light __Mid __Heavy

Are you periods painful? __Yes __No How many days does the pain last? _____

Do you get premenstrual lower back pain? __Yes __No

Do you have premenstrual tension? __Yes __No

Do your bowel movements become loose at the beginning of your period? __Yes __No

What color is the blood? __Light red __Red __Dark Red __Purple __Brown __Black

Is there clotting? __Yes __No Do you bleed/spot between periods? __Yes __No

Any pain between periods? __No __ Yes

Gynecologic History

Have you ever been diagnosed with the following conditions…

Uterine fibroids or polyps? ___Yes ___No		Endometriosis?	___Yes ___No
Pelvic adhesions?	___Yes ___No	Polycystic Ovaries?	___Yes ___No
Luteal Phase Defect?	___Yes ___No	Tubal blockage?	___Yes ___No

Others _____

Date of last GYN exam _____ Date of last Pap Smear _____

Have you ever had a cervical biopsy, surgery, cauterization or conization ? ___Yes ___No

Have you ever had pelvic inflammatory disease? __No __Yes If so, how were you treated for it?

_____

Do you have chronic vaginal discharge? __Yes __No Regular yeast infections? __Yes __ No

Date and result of last mammogram _____

Have you used an IUD? __Yes __No Do you have any problems with intercourse? __Yes __No

Do you know if you ovulate on your own? __Yes __No If so, on what day of your cycle? ____

Have you taken contraceptives? __Yes __No When and for how long? _____

Have you taken any medications for gynecological conditions other than contraceptives?

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

Obstetrical History (if any)

Date	Time to conceive	Length or pregnancy (weeks)	Outcome (e.g. live birth, miscarriage, ectopic,aborption)	Complications or birth defects

Infertility History

How long have you been trying to get pregnant? _____ years _____ months

Is your partner supportive of your wish to conceive? __Yes __No

Has your husband/partner had a fertility workup? __Yes __No What's the results?_____

Have you had a diagnosis relating to infertility? __Yes __No What was it?_____

Do you have stressful occupation? __Yes __No Do you exercise regularly? __Yes __No

How is your sexual energy? ___Low ___Normal ___High

Do you have excessive facial/body hair? __Yes __No Do you have very oily skin? __Yes __No

Have you been exposed to any known environment toxins or hormones? __Yes __No

Have you experienced excessive loss of head hair? __Yes __No

Have you ever taken Assisted Reproductive Technologies (IUI, IVF, etc) procedure?

__Yes __No Date & Result _____

Previous Infertility Tests (please give result and date and if known)

Ovulation Predictor	__ No	__ Yes	Result _____
BBT Charts	__ No	__ Yes	Result _____
HSG (X-ray of tubes)	__ No	__ Yes	Result _____
Hysteroscopy	__ No	__ Yes	Result _____
Laparoscopy	__ No	__ Yes	Result _____
Day 3 FSH, Estradiol	__ No	__ Yes	Result _____
Prolactin	__ No	__ Yes	Result _____
TSH	__ No	__ Yes	Result _____
Progesterone	__ No	__ Yes	Result _____
Semen Analysis	__ No	__ Yes	Result _____

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Absolute Holistic Medicine is based on Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

Signature Date

Men's Fertility History

Name_____ Birth date of husband/partner _____

Present Age _____ Present Weight _____ Height_____

How long have you and your partner been trying to conceive? _____

How would you define your sexual energy? __ No __ Yes

Do you have any history of the following?

Prostatitis	__ No __ Yes
Epididymitis	__ No __ Yes
Orchitis	__ No __ Yes
Previous vasectomy	__ No __ Yes
Testicular tumor	__ No __ Yes
Injury to testes	__ No __ Yes
Undescended testicles	__ No __ Yes
Gonorrhea	__ No __ Yes
Chlamydia	__ No __ Yes
Syphilis	__ No __ Yes
Nonspecific urethritis	__ No __ Yes
Difficulty with erection	__ No __ Yes
Difficulty with ejaculation	__ No __ Yes
Exposure to radiation	__ No __ Yes
Exposure to chemicals	__ No __ Yes
Exposure to substances	__ No __ Yes

How much caffeine does your partner drink per day? _____ cups

How much cigarettes does your partner smoke per day? _____ for how long? ___ years

How much alcohol does your partner drink per week? _____ what kind _____

Have you had a fertile workup? __ No __ Yes

If yes, what is your sperm count? __Below normal __Normal Number _____

What is the sperm motility? __Below normal __Normal Notes _____

What was the sperm morphology? __Abnormal __Normal Notes _____

List all significant **medical illnesses and surgical procedures** which you have experienced

_____
_____
_____
_____

List current **medications**: State the name of the drug, reason partner is taking it, and for how long?

Medication	Reason	Duration/Last time taken
_____	_____	_____
_____	_____	_____
_____	_____	_____