STILLPOINT ACUPUNCTURE
Transforming lives through the power of Chinese medicine

Infertility Medical History

Name: _____ Age: _____ Today's Date: _____

1.	How long have you been trying to get pregnant?
2.	How has this experience affected your life?
3.	Why do you want to have a child?
4.	How would you like to incorporate Chinese Medicine into your fertility plan (i.e., are you planning to use Chinese Medicine only or are you also pursuing other reproductive strategies)?
5.	Describe what you see as your timeline for achieving pregnancy? Is there a point in time that you will consider other options such as IVF, donor eggs or adoption?
6.	If it were recommended by your practitioner, would you be willing to try to AVOID conceiving for 3-6 months while we try to regulate your periods and address the underlying cause of your infertility? If you have already started an IVF or other medicated cycle, this does not apply to you. ☐ Yes ☐ No
7.	Are you and your partner in agreement about these answers? ☐ Yes ☐ No If no, please describe the significant differences.

Menstrual History

Age of first period:	Were you given medication to start your first period? ☐ Yes ☐ No	First day of last menstrual period:
Are your periods regular? ☐ Yes ☐ No	How many days in between your periods?	How many days do you bleed?
What color is the blood? ☐ Black or purple ☐ Dark Red ☐ Bright Red ☐ Light Red ☐ Pale Red ☐ Brown	Do you have any spotting before period begins? ☐ Yes ☐ No	Do you have any spotting around mid-cycle? ☐ Yes ☐ No
Do you have pain with your period? ☐ Yes ☐ No	If yes, where? ☐ Abdomen ☐ Back ☐ Head ☐ Legs	When do you feel the pain? ☐ Before the flow ☐ During the flow ☐ After the flow is mostly over
Describe the quality of the pain: ☐ dull ☐ sharp ☐ burning ☐ pulling ☐ distending	Describe the severity of the pain: ☐ severe ☐ moderate ☐ mild	Do you experience breast distention? ☐ None ☐ Mild ☐ Moderate ☐ Severe When?
Do you have clots? ☐ Yes ☐ No If yes, are they: ☐ large ☐ medium ☐ small	Have you noticed that once the clots pass, the pain does too? ☐ Yes ☐ No	Do you experience PMS? ☐ Rage ☐ Irritability ☐ Sadness ☐ Depression Other:
Do you have appetite changes around period? ☐ Increased ☐ Decreased Cravings:	Do you have bowel changes around period? ☐ Loose Stools ☐ Constipation	Do you have a history of an eating disorder? ☐ Yes ☐ No
Have you ever stopped menstruating due to low body weight? ☐ Yes ☐ No	Do you have a history of rape/sexual abuse? ☐ Yes ☐ No	How often do you get urinary tract infections and/or yeast infections?

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Have you been diagnosed with any of the following? (check all that apply)

☐ Chlamydia	☐ Gonorrhea	☐ Genital Herpes	☐ PID
☐ HIV	☐ Hepatitis B or C	☐ Genital Warts (HPV)	☐ Endometriosis
☐ PCOS	☐ Fibroids	☐ Thin Endometrium	☐ Ovarian Cysts
☐ Low Estrogen	☐ Low Progesterone	☐ Anovulation	☐ Blocked Fallopian Tube

Results of most recent medical tests:

TSH	FSH	LH
Progesterone	Estradiol	Other:

Contraceptive/Ovulation History (check all that apply)

Age of first intercourse:_____ Was it consensual? ☐ Yes ☐ No

☐ Oral contraceptives # of yrs./mos.	☐ Contraceptive patch # of yrs./mos.
☐ Depo Provera # of yrs./mos.	☐ Nuva Ring # of yrs./mos.
☐ Norplant # of yrs./mos.	☐ IUD # of yrs./mos.
☐ Diaphragm # of yrs./mos.	Other: # of yrs./mos.

1. Do you typically know when you ovulate each month? ☐ Yes ☐ No
2. Have you ever kept track of your Basal Body Temperature (BBT)? ☐ Yes ☐ No
3. If yes, did you notice anything in particular about your temperatures? _____
4. Do you notice changes in your cervical mucus or vaginal discharge during the month? ☐ Yes ☐ No
5. Do you think your vaginal discharge is: ☐ too much ☐ normal ☐ too scanty
6. Do you see slippery "egg-white" discharge around mid-cycle? ☐ Yes ☐ No

Pregnancy History

# of pregnancies	# of live births	# of miscarriages
# of ectopic pregnancies	# of "chemical pregnancies	# of abortions

Fertility Treatment History

Treatment	How many times	Number of Positive Results
Stimulating medications (e.g, Clomid, Follistim)		
IUI		
IVF		
Frozen Cycle		
Donor Egg Cycle		

General Health and Fitness

1.	What kinds of exercise do you get now and how often?
2.	Please describe a day's typical diet, including breakfast, lunch, dinner, snacks and all beverages:

3.	Please list all medications / herbs / supplements you take on a regular basis:
4.	What do you do to prevent or alleviate stress?
5.	Do you have a spiritual practice? If so, what kind?
6.	What do you do for fun?
7.	What are you passionate about?
8.	What kind of work do you do? Do you enjoy it? How many hours do you work in a week?

Male Partner's History *(Skip this section if you do not have a male partner)*

1.	Please list all medications / herbs / supplements your partner takes on a regular basis?
2.	Has your partner ever been diagnosed with high cholesterol or high blood pressure? ☐ Yes ☐ No
3.	When was your partner's last semen analysis?
4.	Please check any of the following that were noted in that analysis: ☐ Low sperm count ☐ Poor motility ☐ Poor Liquefaction ☐ Poor morphology ☐ Low volume ☐ Other:
5.	Does your partner have a history of any of the following? ☐ Testicular Infection/Epididymitis ☐ Testicular Cancer ☐ Small Testicles ☐ Varicocele ☐ Low Testosterone ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ HIV ☐ Hepatitis B or C ☐ Genital Warts (HPV) ☐ Prostate Inflammation or Cancer
6.	Does your partner have any of the following sexual issues: ☐ Difficulty maintaining erection ☐ Premature Ejaculation ☐ Low Libido ☐ Other:

Is there anything else you would like us to know?

Name of your infertility specialist:_____

Name of your OB/Gyn:_____

Do we have your permission to discuss your treatment with them? ☐ Yes ☐ No

Signature: _____