NORTH PARK ACUPUNCTURE

CONFIDENTIAL FERTILITY QUESTIONNAIRE

Please answer the following questions. This information is completely confidential. There are some very personal questions and if you feel uncomfortable, you can leave them blank.

Name:_____ Age: _____ Date:_____

Has your physician given you a reason for your infertility? If so, please explain:_____

_____

Have you ever been pregnant before? ☐Yes ☐ No

Have you ever had any of the following?

☐Abortion ☐Blighted Ovum ☐Miscarriage ☐Chemical Pregnancy

Do you have any children? ☐Yes ☐No

If so, how many and how old are they?_____

Did you have: ☐Vaginal Birth/s ☐C-Section

FERTILITY HISTORY

1. How long did you try to get pregnant naturally? _____
2. Have you had any of the following tests or surgeries?
   ☐Hysterosalpingogram ☐Fibroid Removal ☐Cyst Aspiration
   ☐Tube Removal ☐Ovary Removal
3. Have you had any of the following conditions?
   ☐Fibroids ☐Ovarian ☐Cysts ☐Blocked Tubes ☐Endometriosis ☐Fibromyalgia
   ☐Lupus ☐Chronic Fatigue Syndrome ☐Lacking Anti-Coagulant in Blood
4. Has your husband been examined by a physician? ☐Yes ☐No
5. Were any of the following problems found:
   ☐Low sperm count ☐Poor morphology ☐Sperm unable to penetrate egg ☐Varicocele
6. Are you going to be having any medical procedures performed?
   ☐IVF ☐ Frozen Embryo Transfer ☐IUI If so, approximately when? _____
7. Have you had any of the following procedures previously? If so, please list the date:
   ☐IVF _____ ☐Frozen Embryo Transfer _____ ☐IUI _____
8. Are you currently on any infertility medications? ☐Yes ☐No Please list:_____
9. Have you ever tested positive for hypothyroidism or hyperthyroidism? ☐Yes ☐No
10. How many days is your cycle? (i.e. 28 days)_____
11. How long is your menses? (i.e. 5 days) _____

12. Please check the daily description of your menstrual flow:

	Light	Medium	Heavy
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
More than 5 Days			

13. What color is the blood of your menstrual flow?

☐Light, watery red ☐Bright Red ☐Dark Red ☐Brown ☐Clots

14. Do you have pain during intercourse? ☐Yes ☐No
15. Do you get PMS? ☐Yes ☐No Please list your primary symptoms:_____

_____

16. Do you get cramps on your period? ☐Yes ☐No If so, what day/s?_____

17. Have you ever had an abnormal pap smear? ☐Yes ☐No If so, when and how was it resolved?

_____

18. Do your breasts become tender before/during your period? ☐Yes ☐No
19. Do you have fibrocystic breast disease? ☐Yes ☐No ☐Unknown
20. Have you ever had or do you currently have any breast lump/s? ☐Yes ☐No

If so, did you have any treatment for them?_____

21. Do you have a history of breast cancer? ☐Yes ☐No

If so, please list who had breast cancer in your family _____

22. Have you ever taken your basal body temperatures? ☐Yes ☐No
23. If so, what was your average temperature?_____
24. Do you have high blood pressure? ☐Yes ☐No
25. Do you have any heart problems? ☐Yes ☐No

If so, please describe:_____

26. How is your stress level? Low Stress Medium Stress High Stress
27. Do you exercise? ☐Yes ☐No If so, please list the type/s of exercise and how often _____

_____

28. What do you do for relaxation? _____
29. Have you had any counseling since trying to become pregnant? ☐Yes ☐No
30. Have you ever been sexually abused? ☐Yes ☐No

Any comments you wish to add _____

_____