monica patt
ACUPUNCTURE

10118 A 124 Street
Edmonton, Alberta T5N
1P6
780.705.0444

Female Fertility Intake Supplementation

Date (m/d/y):

Name : DOB(m/d/y): Age:

Are you trying to conceive? Y N How long have you been trying?

Have you received a diagnosis related to infertility? Y N Diagnosis:

Menstrual History

Age of first Period: Are your periods regular? Y N

Cycle length: Duration: Date of last period?

Flow is: ☐normal ☐heavy ☐light

Color is: ☐red ☐dark ☐purple ☐light brown ☐brown

Do you have clotting? Y N Size of clots: ☐dime ☐quarter ☐larger

Color of clots: ☐red ☐dark ☐purple ☐light brown ☐brown

Do you bleed between cycles? Y N Do you have spotting before your period? Y N

Do you bleed at ovulation? Y N If yes, for how many days?

PMS Symptoms

Please check off your symptoms when you experience them

	Before menstruation	During menstruation	At Ovulation/Midcycle
Emotional			
Breast swelling/Tenderness			
Back Pain			

Acne			
Headaches			
Bloating			
Cramps			

If you have cramping is it: ☐Dull and achy ☐Sharp and stabbing ☐General lower back pain

Does heat help? Y N

Ovulation

Do you ovulate on your own? Y N On what day do you ovulate?

Have you taken medications (ie: clomid) to help you ovulate? Y N

When? For how long?

Do you experience any of the following when you *ovulate*?

☐breast tenderness ☐lower back pain ☐lower abdominal pain ☐stretchy clear mucous

Do you have, or have you experienced:

☐Hot Flashes ☐Increased Facial/Body Hair ☐Breast Discharge

☐Vaginal Discharge ☐Weight Gain of more than 10 lbs ☐Weight Loss of more than 10 lbs

Date of last pap test (m/d/y) _____/_____/_____

Gynecology

Do you or have you experienced:

☐Vaginal Dryness ☐Endometriosis ☐Regular yeast infections ☐Pain During Intercourse

☐Recurrent Vaginitis ☐Thin Endometrial lining ☐UTI or Bladder infections ☐Bleeding with Intercourse

☐Abnormal Pap Smears ☐Uterine Fibroids/Polyps ☐Chlamydia ☐High Libido

☐Abnormal Uterus Shape ☐Ovarian Cysts ☐Gonorrhea ☐Low Libido

☐Pelvic Adhesions ☐Polycystic Ovarian Syndrome (PCOS) ☐Syphilis ☐<25 day cycle

☐Pelvic Infection	☐Premature Ovarian Failure (POF)	☐Genital herpes	☐>35 day cycle
☐Pelvic Inflammatory Disease (PID)	☐Cryo (freezing) or surgery of the cervix	☐Genital Warts	☐ Irregular periods
☐Any pelvic abnormalities		☐ Mycoplasma	☐ Spotting between periods
			☐Loose bowel movement at onset of period

☐ Other _____

Frequency of Intercourse _____x/week/month

Contraceptive Use:

Type	From When to When	Reason Discontinued

Pregnancy History

How long have you been trying to get pregnant? _____

# of Pregnancies: # of Term Births: # of Premature Births:

# of Miscarriages: # of Elective abortions:

Fertility Treatments:

Are you planning for fertility treatments? Y N		☐IUI	☐IVF
Have you ever undergone IUI? Y N		If yes: ☐ Partners Sperm	☐Donor Sperm
# IUI's	Dates:		

What medications were used?

Have you ever undergone IVF? Y N

If yes: ☐Your Egg	☐Donor Egg	☐Partners Sperm	☐Donor Sperm
# of IVF cycles	Dates		