geneva
acupuncture
& bodyworks

501 W State St, Suite 204
Geneva, IL 60134
(331) 248-0657
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WOMEN'S REPRODUCTIVE HISTORY

Age at which menses began _____

Are your periods painful? Yes No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? light normal heavy

What color is the blood? light red / red / dark red / purple / brown / black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

Date of last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____ age(s) _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydia infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How? _____

Date of last pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you taken any medication for gynecological conditions other than contraceptives? Yes No

Medication	**Reason**	**How long**

Have your cycles changed since they began? Yes No

How? _____

Do you ovulate on your own? Yes No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? Yes No

Do you get premenstrual low back pain? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What type(s)? _____

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WOMEN'S REPRODUCTIVE HISTORY CONT.

Have you taken medication to help you ovulate? Yes No
When? _____
How long? _____
Have your fallopian tubes been evaluated medically? Yes No
What were the results? _____

Have you had any tubal operations? Yes No
Have you had any hormone laboratory tests performed? Yes No
What were the results? _____

Do you have a single partner with whom you have been trying to conceive? Yes No
How long have you been married or living together? _____
Has he had a fertility workup? Yes No
What were the results? _____

Is your partner supportive in your wish to conceive? Yes No
How is your sexual energy? low normal high
Do you douche regularly? Yes No
With what? _____
Do you use vaginal lubricants? Yes No
Are you more than 20% over your ideal body weight? Yes No
Are you more than 20% below your ideal body weight? Yes No
Do you have a stressful occupation? Yes No
Do you exercise regularly? Yes No
Do you have excessive facial hair? Yes No
Do you have excessively oily skin? Yes No
Have you experienced excessive loss of head hair? Yes No
Have you noticed discharge from your nipples? Yes No
Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No
Have you been exposed to any known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No
Have you taken oral contraceptives? Yes No
When? _____
How long? _____

Have you ever had an IUD? Yes No
When _____
How long? _____
Have you ever taken DepoProvera? Yes No
When? _____
How long? _____
How long have you been trying to conceive? _____
Have you had a diagnosis relating to infertility? Yes No
What was it? _____

Please bring the following lab results if available:

- FSH
- LH
- Estradiol
- Progesterone
- Testosterone
- DHEAS
- TSH
- Free T3
- Free T4
- Prolactin

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MEN'S REPRODUCTIVE HISTORY

How long have you been trying to conceive? _____

How would you define your sexual energy? Below normal / Normal

Do you have undescended testes? Yes No

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you experienced difficulty maintaining erection? Yes No

Have you experienced difficulty ejaculating? Yes No

Have you ever had exposure to any known environmental toxins or hormones? Yes No

Have you experienced any penile discharge? Yes No

Do you regularly experience nocturnal emission? Yes No

Have you had a fertility workup? Yes No

Please provide a copy of lab results or complete the following:

Date			
Volume (2-5 cc)			
Concentration (>20 million)			
Motility (>50%)			
TMS (>40 million)			