integrative wellness center

Dr. Heidi Kao, DAOM, L.Ac. & Associates

Fertility History

Please answer accordingly. Either fill in the answer or circle an option

At what age did your menses begin? _____
Are your periods painful? Yes No
How many days does the pain last? _____
How many days do you normally bleed? _____
What color is the blood?
Light red Red Dark red Purple Brown Black
How heavy is the bleeding? Light Normal Heavy
Is there clotting? Yes No
Do you have premenstrual tension? Yes No
Does your face break out before or during your period? Yes No
Do you have premenstrual breast tenderness? 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? _____
Have your cycles changed since they began? Yes No
If yes, how has your cycle changed?
_____
Do you ovulate on your own? Yes No
On what day of your cycle do you ovulate? _____
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

	Number	Year
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times have you had a D&C?	_____	_____

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 chlamydia? 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 pelvic abnormalities? Yes No
Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had fertility treatments? Yes No
If yes, when and where?
_____
By whom?
_____
What types?
_____
Have you taken medication to help you ovulate? Yes No
When? _____ How long? _____
Have your fallopian tubes been evaluated medically? Yes No
If yes, what were the results?
_____
Have you had any tubal operations? Yes No
Have you had any hormone laboratory tests performed? Yes No
If yes, what were the results?
FSH: _____ LH: _____
AMH: _____ Estradiol: _____
Vitamin D: _____ TSH: _____
Other:
_____
_____

Do you have a single partner with whom you have been trying to conceive? Yes No
How long have you been together? _____

Have they had a fertility work-up? Yes No
If yes, what were the results?
_____
Is your partner supportive of your wish to conceive?
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 the diagnosis?
_____
How is your sexual energy?
Low Normal High
Do you douche regularly? Yes No
If yes, 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

Please share any additional information you're comfortable sharing that will help us better treat you:
_____
_____
_____
_____
_____
_____
_____