

REPRODUCTIVE WELLNESS

ACUPUNCTURE & INTEGRATIVE MEDICINE



Fertility Patient Information Form

Current Diagnosis

Patient Name: _____ Age: _____ Years trying to conceive: _____

Number of	
Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Failed IUI's	
Failed IVF's	

Occupation: _____
Hobbies / Interests: _____
Husband: _____ Occ: _____ Age: _____
Male Factor: _____
Children: Name(s)/Age(s): _____

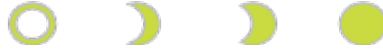
Important Clinical Notes:

Western Diagnosis for Infertility:

OB/GYN: _____ R.E.

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Major Fertility Signs and Symptoms: _____ Cycle Days _____ Days of Bleeding

Regular / Erratic: _____ Clotting: _____ Spotting: _____

PMS Signs: _____ Pain: _____

Cervical Mucus: _____ Ovulation: _____

Color of Blood: _____ Notes: _____

Practitioner: _____ Date: _____

Menstrual and Fertility Update - *At a Glance*

Patient Name: _____

Describe your current menstrual cycle for each of the questions:	Cycle # 1	Cycle # 2	Cycle # 3	Cycle # 4	Cycle # 5	Cycle # 6	Cycle # 7	Cycle # 8
# of days in your Menstrual Cycle								
What cycle day did you ovulate?								
Number of days above 98°	Before Ovulation							
	After Ovulation							
Number of days below 97°	Before Ovulation							
	After Ovulation							
Did you have abundant, stretchy, clear cervical mucus? - If not what did you have?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you experience spotting or cramping at ovulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What symptoms of PMS did you experience?								
Did you have clotting? Size of clots - Dime? Nickel? Quarter?								
Did you have menstrual pain?								
How many days did you bleed?								
Did you have spotting prior to cycle day one?								
How long would it take for you to soak a tampon/pad?								

Menstrual and Fertility Update - *At a Glance*

Medications and Fertility Drugs										
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History of Procedures / Surgeries:

Doctor's Notes: