The Fertility Clinic
4040 North Calhoun Road, Brookfield, Wi 53005, Phone 262-901-0053

Your Name: _____

Date of Birth: _____

# Female Fertility History

Todays' Date: _____

How long have you been trying to conceive? _____

Have you had any diagnosis relating to fertility: ☐ No ☐ Yes
Please describe: _____

Have you had fertility treatments or procedures with a medical doctor: ☐ No ☐ Yes
Doctor's name: _____

| | | | |
|---|---|---|---|
| ☐ ovulation induction | ☐ IUI | ☐ IVF | ☐ FET |
| ☐ others: | | | |

Have you had any of the following fertility blood-work tests / lab tests:
Please include your test results if you have them.

| | | | |
|---|---|---|---|
| ☐ FSH | ☐ prolactin | ☐ repeat miscarriage panel | ☐ others, please list: |
| ☐ Estradiol | ☐ estrogen | ☐ immunology testing | |
| ☐ LH | ☐ progesterone | ☐ thyroid | |
| ☐ AMH | ☐ testosterone | ☐ fasting insulin | |

Have you taken any of the following fertility medications:

| | | | |
|---|---|---|---|
| ☐ clomid | ☐ progesterone | ☐ lupron | ☐ others, please list: |
| ☐ letrozole / femara | ☐ estrogen | ☐ ganirelex | |
| ☐ FSH injectibles | ☐ metformin / glucophage | ☐ growth hormone | |
| ☐ prolactin lowering meds | ☐ anti-coagulants | ☐ immuno-therapy | |

Have your fallopian tubes been evaluated for patency: ☐ No ☐ Yes

Have you had any surgical procedures for fertility: ☐ No ☐ Yes

Have you had any other diagnostic fertility procedures / tests: ☐ No ☐ Yes

## Menstruation

When was your last menstrual period? Start date: _____

Is your menstrual cycle spaced regularly from one month to the next: ☐ No ☐ Yes

How many days are your cycles (day 1-next period): _____

How many days of bleeding do you usually have: _____

How heavy is your menstrual bleeding: ☐ heavy ☐ medium ☐ light

What color is your bleeding: ☐ dark red ☐ bright red ☐ pink ☐ brown

Is there any clotting during your cycle: ☐ No ☐ Yes

Do you have spotting or bleeding between cycles: ☐ No ☐ Yes

Does your blood contain any stringy tissue or mucus: ☐ No ☐ Yes

At what age did you begin menstruating: _____

Have your cycles changed in any way over time: ☐ No ☐ Yes

Have you ever charted your cycles with basal body temperatures: ☐ No ☐ Yes

Which **pre-menstrual** symptoms do you notice before your periods:

| | | | |
|---|---|---|---|
| ☐ breast tenderness | ☐ loose stools | ☐ sensations of heat | ☐ others, please list: |
| ☐ headaches | ☐ constipation | ☐ insomnia | |
| ☐ acne | ☐ low back pain | ☐ irritability | |
| ☐ bloating | ☐ fatigue | ☐ depression | |

Which symptoms do you have **during** your periods:

| | | | |
|---|---|---|---|
| ☐ severe pain | ☐ leg pain | ☐ headaches / migraines | ☐ others, please list: |
| ☐ moderate pain | ☐ back pain | ☐ nausea | |
| ☐ mild / occasional pain | ☐ lower abdominal pain | ☐ vomiting | |

Do you have any comments / questions / concerns about your periods: _____

_____

_____

## Ovulation

Do you ovulate on your own without medications: ☐ No ☐ Yes

On what day of your cycle do you think you ovulate: _____

Do you experience ovarian pain during ovulation: ☐ No ☐ Yes

Do you notice watery or egg-white cervical mucus: ☐ No ☐ Yes

Do you use ovulation predictor kits or a fertility monitor? ☐ No ☐ Yes

Which days of your cycle do you try to time intercourse: _____

How many days between ovulation & your next period (luteal phase): _____

## Pregnancy History

Have you had any pregnancies: ☐ No ☐ Yes

How many children do you have, and their ages: _____

Have you had any miscarriages: _____

Have you had a D&C performed: _____

Have you ever had an abortion: _____

## Contraception History

Are you currently using any contraception: ☐ No ☐ Yes, what type: _____

Have you taken oral contraceptives: ☐ No ☐ Yes, date discontinued: _____
Was the pill for birth control ☐ , problems with your periods ☐ , or both ☐

Have you ever had an IUD: ☐ No ☐ Yes, when: _____

Have you ever used Depo-Provera: ☐ No ☐ Yes, when: _____

## Gynecological History

Have you ever had an ovarian cyst: ☐ No ☐ Yes

Have you ever been checked for uterine fibroids or polyps: ☐ No ☐ Yes

Have you ever had pelvic inflammatory disease: ☐ No ☐ Yes

Have you ever been diagnosed with chlamydia or gonorrhea: ☐ No ☐ Yes

Do you experience frequent yeast infections: ☐ No ☐ Yes

Do you have chronic vaginal discharge: ☐ No ☐ Yes

Do you have vaginal dryness: ☐ No ☐ Yes, do you use lubricants (type): _____

Do you douche: ☐ No ☐ Yes

Have you been diagnosed with pelvic adhesions or uterine abnormalities: ☐ No ☐ Yes

Have you felt any lower abdominal hard or movable masses: ☐ No ☐ Yes

Have you ever had a cervical surgery, or LEEP procedure: ☐ No ☐ Yes

Do you have any breast lumps, masses or fibroids: ☐ No ☐ Yes

Do you have any discharge from your nipples: ☐ No ☐ Yes

Have you had any other gynecological conditions: ☐ No ☐ Yes, Describe: _____

_____

## Your Partner

Do you have a partner with which you are trying to conceive: ☐ No ☐ Yes

Has your partner's fertility been evaluated: ☐ No ☐ Yes
The results of semen analysis and / or urological exam: _____

_____

Has your partner had other reproductive health problems: ☐ No ☐ Yes: _____

_____

## Lifestyle Inquiry

How is your sexual energy: ☐ good ☐ fair ☐ low

How would you describe your stress level: ☐ high ☐ moderate ☐ low ☐ varies greatly

What do you do for relaxation: _____

Do you have difficulty sleeping: ☐ No ☐ Yes, Describe: _____

Do you exercise: ☐ No ☐ Yes, describe activities and frequencies: _____

_____

Your height: _____
Your weight: _____ Does your weight fluctuate much: ☐ No ☐ Yes

**Your typical daily food intake**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Anything you do not or cannot eat: _____

Have you been exposed to any environmental toxins: ☐ No ☐ Yes

Do you smoke cigarettes, use recreational drugs or have a history of doing so: ☐ No ☐ Yes

## Other Health Questions

Have you ever been diagnosed with hypothyroidism: ☐ No ☐ Yes

Have you ever been diagnosed with anemia: ☐ No ☐ Yes

Have you ever been diagnosed with any other blood or clotting disorder: ☐ No ☐ Yes

Are you currently taking any medications: ☐ No ☐ Yes, (please include on medication list)

**Are you currently pursuing any other treatment for fertility, or do you have plans to begin additional fertility treatments in the future of which we should be aware of ?** _____

_____

_____

_____

_____

_____

**Have you tried any other treatments / techniques / recommendations to aid in your fertility that we haven't inquired about?** _____

_____

_____

_____

_____

**Please share any comments, questions or concerns that you feel are relevant to your fertility and that would be helpful for us to know to provide the best treatment and care for you.** _____

_____

_____

_____

_____

_____

The Fertility Clinic

**The Fertility Clinic looks at the body from a holistic perspective. In order to provide the best care, please be as complete as possible.**

**Please complete the following section by making a "X" next to any symptoms that you have experienced within the past 3 months.**

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**Sleep / Energy**
__ difficulty falling asleep
__ difficulty staying asleep
__ restless sleep
__ Lots of dreams
__ Wake up too early
__ Go to bed extra early
__ Need to take naps
__ Tired during the day
__ Mentally fatigued
__ Low sex drive

**Food / Taste / Thirst / Digestion**
__ Lack of appetite
__ Large appetite
__ Eat small portions
__ Eat large portions
__ Aversion to eating
__ Nausea / vomiting
__ Tired after eating
__ Bloating / full feeling
__ Frequent flatulence
__ Heartburn / Reflux
__ Difficulty digesting food
__ Frequent belching
__ Stomach discomfort
__ Frequent hiccups
__ Dry mouth
__ Increased saliva
__ Frequent thirst
__ Lack of thirst
__ Prefers cold water
__ Prefers warm water

**Bowel Movements**
__ Less then 1 / per day
__ More then 3 / per day
__ Mostly firm stools
__ Mostly loose stools
__ Diarrhea
__ Constipation
__ Difficult to pass BM
__ Pain, Before BM
__ Hemorrhoids
__ Black / bloody stools

**Urine**
__ Less then 3 / per day
__ More then 5 / per day
__ Urgency / incontinence
__ Wake up to urinate
__ Dark yellow or brown
__ Blood in urine
__ Cloudy urine
__ Pain or burning
__ Delayed urination
__ Strong odor

**Body**
__ Gaining weight
__ Losing weight
__ Upper back pain / stiff
__ Lower back pain / ache
__ General body aches
__ Tend to feel warm / hot
__ Tend to feel cool / cold
__ Cramping in the limbs
__ Numbness in the limbs
__ Twitching in the limbs
__ Edema / swelling limbs
__ Heavy / weak limbs
__ Knee clicks or pops
__ Warmer in the evening
__ Shiver frequently
__ Sweat with little effort
__ Sweat at night
__ Sweat on palms / feet
__ Yellowish sweat
__ Oily sweat

**Respiratory**
__ Asthma / wheezing
__ Shortness of breath
__ Hay fever / allergies
__ Persistent cough
__ Coughing blood
__ Phlegm production
__ Frequent sighing
__ Frequent yawning

**Chest**
__ Chest pain
__ Heavy feeling in chest
__ Tightness in the chest
__ Irregular heart beat
__ Racing heart beat
__ Aware of heartbeat
__ Pain in the ribcage

**Eyes / Ears / Nose / Throat / Mouth**
__ Blurry vision
__ See floating spots
__ Dry eyes
__ Redness in the eyes
__ Watery eyes
__ Itchy eyes
__ Pressure in the eyes
__ Earaches
__ Discharge from ears
__ Excess ear wax
__ Bleeding from ears
__ Ringing sound
__ Difficulty hearing
__ Frequently sneeze
__ Congested sinuses
__ Frequent runny nose
__ Nose bleeds
__ Itchy nose
__ Dry nostrils
__ Toothaches
__ Loose teeth sensation
__ Teeth Grinding
__ Bleeding gums
__ Sore / tender tongue
__ Sores inside the mouth
__ Sores outside mouth
__ Dry / cracked lips
__ Soreness in the throat
__ Itchy throat
__ Swelling in the throat
__ Stuck feeling in throat
__ Difficulty swallowing

**Head / Hair**
__ Foggy feeling in head
__ Buzzing noise in head
__ pressure in the head
__ Headaches / Migraines
__ Frequently dizzy
__ Faint fairly often
__ Itchy scalp
__ Dry brittle hair
__ Greasy Hair
__ Dandruff
__ Hair loss

**Skin**
__ Oily skin
__ Dry or flaking skin
__ Itchy skin
__ Rash / acne / eczema
__ Redness / discoloration
__ Growths or masses
__ Varicose veins
__ Bruise easily
__ Slow healing wounds
__ Easy bleeding
__ Warm to the touch
__ Cool to the touch

**Mental / Emotional**
__ Feel "stressed out"
__ Impatient / Irritable
__ Easy to anger
__ Nervous / anxious
__ Sadness / Depression
__ Lack drive / willpower
__ Forgetfulness
__ Mind not clear / Foggy
__ Worry / racing thoughts
__ Excess fear / fright
__ Frequently insecure
__ Poor memory
__ Lack emotional support
__ Family / Home Stress

**Men Only**
__ Genital pain
__ Impotence
__ Genital sores
__ Lump in testicles
__ Penis discharge
__ Nocturnal emission

**Women Only**
__ Has given birth to child
__ Past menopause
__ In menopause
__ < 25 day cycle
__ > 35 day cycle
__ Irregular cycle
__ Periods < 3 days
__ Periods > 6 days
__ Heavy periods
__ Light periods
__ Periods contain clots
__ Pain before periods
__ Pain during periods
__ Pain after periods
__ Bleed between periods
__ Premenstrual tension
__ Breast pain / tender
__ Breast lumps / masses
__ Vaginal discharges
__ Uterine prolapse

The Fertility Clinic

| Patient Name: | | Date of Birth: |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |
| Phone: | Secondary Phone: | |
| Occupation: | Email: | |
| How did you hear about us?: | | |

## Informed Consent

I understand The Fertility Clinic at Practice Longevity may record medical and other information concerning my treatments in electronic or other physical form. Such information may be released by the clinic for the purposes outlined on this form. I understand that portions of my medical records may be disclosed to qualified non-clinician personnel for the purpose of conducting scientific or statistical research, management or financial audits without my consent. I understand that no guarantees have been made to me as a result of treatment or medical examination at Practice Longevity.

## Records Release Authorization

- I understand that I am fully responsible for my bill
- I authorize the use of this form for all of my insurance submissions
- I authorize release of information to all of my insurance companies
- I direct my previous, and current, health care providers to release medical records to this clinic
- I authorize my clinician to act as my agent to obtain payment from my insurance company
- This authorization is not intended to allow the release of records regarding my treatments for services requiring a restricted release under State and Federal Law

## Notice of Privacy Practices

I have received a copy of the *Practice Longevity* notice of privacy paperwork. I understand the paperwork defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal privacy rights.

Patient's Signature Date

Witness Signature Date

The Fertility Clinic

## Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at The Fertility Clinic at Practice Longevity. I understand that Acupuncturists practicing in the state of Wisconsin are not considered to be primary care providers. Our practitioners at Practice Longevity recommend that you use complementary health care as supplement to your primary care physician.

**Initial here_____ Acupuncture:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin at certain points on or near the surface of the body. Acupuncture is typically a safe method of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

**Initial here_____ Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic as soon as possible.

**Initial here_____ Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect the Acupuncture staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that there may be other treatment alternatives, including treatment which might be offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____

## Please List all Medications, Vitamins, and Supplements

| Name (Last, First, Middle) | Date |
|---|---|
| | |

**Please List Any Prescription Medications - Over The Counter Medications - Supplements - Herbs**

| Medication / Supplement: | Reason: | Dose Taken: | How Long: |
|---|---|---|---|
| | | | |
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## Medical History

| Please list any allergies or history of allergic reactions | Any major illnesses, surgeries, or injuries in the past |
|---|---|
| | |

Indicate any significant illnesses that you or a close relative had. Use an "**X**" for you, "**P**" for Parent or "**S**" for Sibling.

___ ___ HIV / Aids
___ ___ Alcohol / Drug Addiction
___ ___ Eating Disorder
___ ___ Arthritis
___ ___ Asthma
___ ___ Bladder Disease
___ ___ Colitis / Bowel Disorders
___ ___ Diabetes
___ ___ Mononucleosis
___ ___ Gall Stones
___ ___ Neuralgia
___ ___ Epilepsy / Seizures
___ ___ Chronic fatigue
___ ___ Obesity / Overweight
___ ___ Multiple Sclerosis
___ ___ Stroke
___ ___ Hepatitis A - B - C
___ ___ Candida
___ ___ Cancer
___ ___ Thyroid Problems
___ ___ Ulcers
___ ___ Rheumatism
___ ___ Scarlet Fever
___ ___ Hernia
___ ___ Heart Disease
___ ___ Emotional Imbalance
___ ___ STD
___ ___ Lyme Disease
___ ___ Autoimmune Disease Other
___ ___ Kidney Disorder
___ ___ Emotional / Physical Abuse
___ ___ Bowel / Digestive Issues
___ ___ Bleeding / Blood Disorder
___ ___ Other: