Jade Clinic of Acupuncture and Preventive Medicine

Women Fertility Questionnaire

Name:

Date of Birth:

Height:

Weight:

Mailing Address:

Mobile Phone Number:

Email Address:

Gynecological 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 ☐

Do you have any eggs-white-liked virginal discharges during the ovulation?

A lot ☐ A little ☐ No ☐

Do you have any other virginal discharges? Yes ☐ No ☐

How is it look like? _____ What is the color?

Do you have any premenstrually tension? Yes ☐ No ☐

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

Do your breasts become tender premenstrually?-not often, once a while

Yes ☐ No ☐

Do you bleed or spot between periods? Yes ☐ No ☐

Are your menstrual cycles spaced irregularly? Yes ☐ No ☐

Date of last menstrual period(LMP):

Date of the period before last one (PMP):

	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? _____ _____

When did the miscarriage occurred? ____ ____(wks)

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

Have you ever been diagnosed with uterine fibroids or polyps? 1-4cm 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 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 ☐

What were the result? Both sides not open.

Have you had any tubal operations? Yes ☐ No ☐

Have you had any hormone laboratory tests performed? Yes ☐ No ☐

What are the lab tests results:

AMH:

FSH:

LH:

E2:

Progesterone:

Testosterone:

PRL:

TSH:

Do you have any gynecological surgeries / endoscopic procedures?

General Medical History

1) Circle any of the following medications you are taking:

Antibiotic/ Antifungal ☐

Antidepressants ☐

Anti Diabetes / Insulin ☐

Aspirin/Tylenol ☐

Chemotherapy ☐

Heart medication ☐

Hormones ☐

Radiation ☐

Relaxants / sleeping pills ☐

Thyroid ☐

Ulcer medications ☐

2) Circle any of the following conditions if you:

diet often ☐

do not exercise regularly ☐

are under excessive stress ☐

are taking supplemental vitamins ☐

salt food without tasting ☐

are exposed to chemicals ☐

are exposed to cigarette smoke ☐

are a vegetarian ☐

3) Review of systems

Check any symptoms of present significance.

A. Dietary Matters

Thirsty ☐ Prefer warm drink ☐ Feel bloated after meal ☐ Have bad breath ☐

B. Chills, Fever and Perspiration

A low-grade fever ☐ Sensitive to cold ☐ Perspiring easy ☐ Perspiring at night ☐

C. Sleeping

Insomnia ☐ Often dream at night ☐ Sleepy during day ☐ Must take sleeping pills ☐

D. Defecation and Urination

Constipation ☐ Loose stool ☐ Frequent urination ☐ Often urinate at night ☐