# 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 囗 No 囗**

**How many days does the pain last?**

**How many days do you normally bleed?**

**How heavy is the bleeding? Light 囗 Normal 囗 Heavy 囗**

**What color is the blood? Light Red 囗 Red 囗 Dark Red 囗 purple 囗 Brown 囗 Black 囗**

**Is there clotting? Yes 囗 No 囗**

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

**A lot** **囗 A little 囗 No 囗**

**Do you have any other virginal discharges? Yes 囗No 囗**

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

**Do you have any premenstrually tension? Yes 囗 No 囗**

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

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

**Yes 囗 No 囗**

 **Do you bleed or spot between periods? Yes 囗 No 囗**

**Are your menstrual cycles spaced irregularly? Yes 囗 No 囗**

**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 囗 No 囗**

**Have you ever been diagnosed with endometriosis? Yes** **囗 No 囗**

**Have you been diagnosed with** **pelvic adhesions? Yes囗 No 囗**

**Have you been Diagnosed with any pelvic abnormalities? Yes 囗 No 囗**

**Have you taken any medications for gynecological conditions other than contraceptives?**

**MEDICATION REASON HOW LONG**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Have you had fertility treatments? Yes 囗 No 囗**

**If yes, when and where?**

**By whom?**

**What types?**

**Have you taken medication to help you ovulate? Yes 囗 No 囗**

**When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have your fallopian tubes been evaluated medically? Yes 囗 No 囗**

**What were the result? Both sides not open.**

**Have you had any tubal operations? Yes 囗 No 囗**

**Have you had any hormone laboratory tests performed? Yes囗 No 囗**

**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 **囗**

Antidepressants **囗**

Anti Diabetes / Insulin **囗**

Aspirin/Tylenol **囗**

 Chemotherapy **囗**

Heart medication **囗**

Hormones **囗**

Radiation **囗**

Relaxants / sleeping pills **囗**

Thyroid **囗**

Ulcer medications **囗**

2) Circle any of the following conditions if you:

 diet often **囗**

do not exercise regularly **囗**

are under excessive stress **囗**

are taking supplemental vitamins  **囗**

salt food without tasting **囗**

 are exposed to chemicals **囗**

 are exposed to cigarette smoke **囗**

are a vegetarian **囗**

1. Review of systems

Check any symptoms of present significance.

A. Dietary Matters

 Thirsty  **囗** Prefer warm drink **囗** Feel bloated after meal**囗** Have bad breath **囗**

B. Chills, Fever and Perspiration

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

C. Sleeping

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

D. Defecation and Urination

Constipation  **囗** Loose stool **囗** Frequent urination**囗** Often urinate at night **囗**