TRINITY ACUPUNCTURE
4305 Torrance Blvd., Suite 208
Torrance, CA 90503
310.371.1777

FERTILITY HISTORY

CONFIDENTIAL

Date: _____
Name: _____
DOB: _____ (_____y.o.)

Do you have a single partner with whom you have being trying to conceive? Yes _____ No_____

How long have you been trying? _____
Libido: Low _____ Normal _____ High _____

FERTILITY WORKUP (for Dr to complete)
FSH _____ [<10mlU/mL]
E2 _____ [80]
AMH _____ [2-4]
AFS _____ [7-10, 2-10mm]
HSG _____
US _____
SIH _____
Hyster _____

MEDICAL HISTORY
Check any that apply to you (past or present):
Abnormal pap smear _____
Cervical biopsy, cauterization or any other cervical procedures _____
Venereal disease _____
Frequent yeast infections _____
Chronic vaginal discharge _____
Vaginal sores/warts _____
Pelvic inflammatory disease _____
Endometriosis _____
PCOS _____
Pelvic adhesions _____
Structural anomalies (e.g., uterine septum, bicornuate uterus, etc) _____
Oral contraceptives _____
IUD _____
DepoProvera _____

List any medications that you are on:

Medication	Reason	How long

FERTILITY TREATMENT
List any reproductive technology procedures you have undergone (IUI, ICSI, IVF, etc):
_____
_____

CYCLE INFORMATION

Last menstrual period: _____
How many days of bleeding? _____
Flow:
Light _____ Normal _____ Heavy _____
Color:
Light red ___ Red ___ Dark Red ___ Brown ___
Clots: Yes _____ No _____
Painful: Yes _____ No _____ (which days? _____)
How long are your cycles? (e.g., 28-30 days) _____
Regular _____ Irregular _____
Describe PMS symptoms if any:
_____
_____

OVULATION

Do you ovulate on your own? Yes _____ No _____
On which day of your cycle? _____ Don't know ____
Fertile (egg-white) mucus during this time?
Yes _____ No _____
Scanty _____ Normal _____ Profuse _____

PREGNANCIES

	Number	Years
Children		
Miscarriage		
Abortion		
D&C		

LIFESTYLE
Stress level: Low _____ Moderate _____ High _____
Smoking: _____
Recreational drugs: _____
Caffeine: _____ cups a day
Alcohol: _____ drinks a week
Any exposure to environmental toxins?
_____

Describe your execise regimen:
_____
_____

Are you 20% over your ideal body weight? _____
Are you 20% below your ideal body weight?_____

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MEN'S HISTORY

Please complete with your partner or to the best of your knowledge:

LIFESTYLE
Stress level: Low _____ Moderate _____ High _____
Smoking: _____
Recreational drugs: _____
Caffeine: _____ cups a day
Alcohol: _____ drinks a week
Any exposure to environmental toxins?
_____

Describe your execise regimen:
_____
_____

Are you 20% over your ideal body weight? _____
Are you 20% below your ideal body weight?_____

FERTILITY
Fertility workup: Yes _____ No _____
If so, when? _____
Results:
Concentration: _____ [>15-20 mil/mL]
Volume: _____ [>1.5ml]
Motility: _____ [>40-50%]
Morphology: _____ [>30-40%]

Any other urogenital disorders (e.g., prostatitis, ED, varicoceles, etc): _____

History of use of anabolic steroids or testosterone:
Yes _____ No _____

COMMENTS/NOTES