



Blessing Acupuncture

150 DAVIS LANE, MONTEREY, CALIFORNIA | (831)333-1434 | WWW.BLESSINGACU.COM

Personal Information

Date / /		First Name		Last Name		Called Name	
Age	Home Phone () -	Work Phone () -	Date of Birth / /		Occupation		

Fertility

How long have you been trying to conceive? _____

Are you under the care of another fertility specialist, RE, OBGyn or physician? Yes No
(if yes) Name: _____ Phone: _____

Are you currently undergoing, or planning to undergo, any ART procedures such as IVF, donor eggs/sperm, IUI, or fertility medication? Yes (please explain below) No

Past Fertility Treatments

Date	Natural, IUI, IVF, Donor egg, Donor sperm	Medications Used	Number of Mature Eggs Transferred	Pregnancy? Yes / No	If Miscarriage, which week?

Fertility Diagnosis

Do you have a western fertility diagnosis such as:

- Elevated Follicle Stimulating Hormone (FSH) Yes No
- Endometriosis Yes No
- Polycystic Ovary Syndrome (PCOS) Yes No
- Premature Ovarian Failure (POF) Yes No
- Low Progesterone Levels (Luteal Phase Defect) Yes No
- Anti-sperm Antibodies Yes No
- Thin Endometrial Lining Yes No
- Other Yes No



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Fertility Procedures

Have you had your fallopian tubes and uterus evaluated?

Yes No

- Laparoscopy
- Hysterosalpingogram (HSG)
- Ultrasound

Yes No

Yes No

Yes No

Have you had any blood work done?

Yes No

- Are the lab tests available?

Yes No

Menstruation

At what age did you get your first menses _____

Date of the first day of your last period _____

How many days do you bleed in a typical cycle (How many days does your period last) _____

Do your cycles come at regular intervals? Yes No

If regular, how long is a typical cycle (Days from one period to the next) _____

If irregular, how many times per year do you get your period _____

What is the color of the menstrual blood on the following days?

	Day 1	Day 2-3	Day 4-6	Day 7+
Pale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bright Red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the constitution and amount of the blood on the following days?

	Day 1	Day 2-3	Day 4-6	Day 7+
Watery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following before or during your period?

- Breast tenderness Yes No
- Breast distention Yes No
- Loose stool Yes No
- Acne Yes No
- Mood changes Yes No
- Cramping Yes No
- Bearing down sensation Yes No



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- Breast lumps Yes No
- Food cravings Yes No
- Low back pain Yes No

- Does your PMS feel better with? Yes No
- Heat Yes No
 - Exercise Yes No
 - Rest Yes No

Ovulation

- Do you ovulate regularly on your own? Yes No
- Have you taken medication to help you ovulate?
(specify) _____ Yes No
- Do you monitor your Basal Body Temperature? Yes No
- Do you use Ovulation Predictor Kits? Yes No
- Do you experience any pain or discomfort around the time of ovulation?
(describe) _____ Yes No
- Do you notice a change in fertile mucus around ovulation? Yes No

Sexual History

- If trying to get pregnant, do you practice timed intercourse? Yes No
- Do you suffer from pain with intercourse? Yes No
- Do you use any of the following?
- Oral contraceptives? Yes No
How long? _____
 - Intrauterine Device (IUD)? Yes No
 - Vaginal lubricants? Yes No
- How would you describe you libido? Low Normal High

Obstetrics History

- Number of pregnancies _____
Dates: _____
- Number of children _____
Dates and delivery method (Natural, C-Section, Complications)

- Number of abortions _____
Dates: _____
- Number of miscarriages _____
Dates and week of gestation

- How many times has a D&C been performed? _____
- Have you ever had an ectopic pregnancy? Yes No



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Gynecological History

Have you ever had an abnormal pap smear? Yes No

When _____

Diagnosis/stage _____

Treatment, if any _____

Have you ever had pelvic surgery? Yes No

When _____

Reason _____

Do you have frequent urinary tract infections (UTI)? Yes No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No

Do you have any of the following conditions?

Frequent yeast infections Yes No

Genital sores Yes No

Herpes Yes No

Discharge from nipples Yes No

Endometriosis Yes No

Pelvic adhesions Yes No

Polycystic Ovary Syndrome (PCOS) Yes No

Loss of hair Yes No

Excessive facial hair Yes No

Acne Yes No

Have you had a chlamydial infection? Yes No

When _____

Treatment, if any _____

Have you had any other STDs? Yes No

Have you had a pelvic inflammatory disease? Yes No

When _____

Treatment, if any _____

Have you had uterine fibroids? Yes No

Date _____

Size _____

Are you more than 20% underweight? Yes No

Are you more than 20% overweight? Yes No

List any medications you are currently taking

Name	Condition	Dosage