OLSON ACUPUNCTURE & NUTRITIONAL HEALING
acupuncture | herbal medicine | nutrition therapy

Female Fertility Intake Form

Name:_____ Todays Date: _____
Date of Birth: _____ Age: _____
Have you had acupuncture before? Y N Chinese herbal medicine? Y N
How long have you been trying to conceive?_____
Pregnancies_____ # Miscarriages _____# of abortions_____
Age(s) of Children_____

Date of last menstrual period: _____# days of bleeding:
Cycle length (i.e. 26-30days):_____
Describe your last period flow: ❑ heavy ❑ light ❑ average
Consistency of blood: ❑ watery ❑ thick ❑ average
Age of first menses:_____

Premenstrual Syndrome: Do you experience any of the below symptoms before your period?

❑ Fluid Retention ❑ Cravings ❑ Fluctuating Emotions ❑ Irritability
❑ Fatigue ❑ Breast Tenderness ❑ Acne ❑ Cramping

Other
How many days before period do PMS symptoms start? _____

Period: During your period do you suffer from cramping? Y N
If yes, describe cramping:

❑ Severe ❑Moderate ❑ Mild
❑ Before Period ❑ After Period ❑ During Period

At what age did you begin menstruating? _____
Clotting: Y N
If yes describe clots:
❑ Bright in color ❑ Dark in color ❑ Before period ❑ After period ❑ During period
Bleeding between periods? Yes No If yes how many days?
Describe blood between periods:
❑ bright red ❑ brown ❑ crimson ❑ other_____

Have you been diagnosed with:

❑ endometriosis ❑ PCOS ❑ Ovarian Cysts
❑ Yeast infections/Vaginitis ❑ Hot flashes ❑ Breast Cysts

Other: _____

Ovulation:
Do you experience pain around ovulation? Y N
Do you track your ovulation (circle): BBT Ovulation sticks Other_____
Do your breasts become tender around ovulation? Y N
Do you notice any vaginal discharge around ovulation? Y N

Date of last pap smear _____ Have you ever had an abnormal pap smear? Y N

Have you ever been diagnosed with:

STD	*Current* ❑ *Past* ❑	Prolapsed uterus	*Current* ❑ *Past* ❑
Uterine Fibroids	*Current* ❑ *Past* ❑	Unique shape of uterus	*Current* ❑ *Past* ❑
Pelvic Adhesions	*Current* ❑ *Past* ❑	Frequent bladder Infections	*Current* ❑ *Past* ❑
Pelvic Inflammatory disease	*Current* ❑ *Past* ❑	Polyps	*Current* ❑ *Past* ❑

Have you been evaluated by an OB/GYN for your fertility? Y N If yes, when? _____
Have you been evaluated by an REI for your fertility? Y N If yes, when? _____
Have you had your fallopian tubes evaluated (HSG) Y N
Have you taken medication to help you ovulate? Y N
If yes what kind?_____how many cycles? _____

Have you undergone assisted reproductive treatments? (IUI, IVF, ICSI, etc.) Y N

Month/ Year	Treatment	Clinic	Results

Birth control history:

Type	Duration	When did you stop?	Why did you stop?

Please list all known food or drug allergies: _____
_____
_____
_____

Do you participate in the following physical activities? If so, please indicate how often

Yoga:_____ Running:_____ Fitness classes:_____
Biking:_____ Swimming:_____ Walking:_____
Gym:_____ Other:_____

How would you rate your daily stress levels? low med high

Anything else we should know? _____
_____
_____
_____

Signature_____ Date_____