OLSON ACUPUNCTURE GROUP

Fertility Intake Form

Name:____Todays date: _____________ Date of birth:

Address:____
Home Phone: ______________________Work Phone:_____________________Cell:_______________
Email:____may we include you on our email newsletter? Y / N
Occupation:____________________ Employer ____________________________ Hours/Week ________________

Emergency Contact:
name relationship phone

Primary Physician:
name clinic phone

Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No
How long have you been trying to conceive?_______________
Pregnancies ______ age of children______
Miscarriages ______
of abortions ______

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

Premenstrual Syndrome: Do you experience any of the below symptoms?
☐ Fluid Retention ☐ Cravings ☐ Fluctuating Emotions ☐ Irritability ☐ Depression
☐ Fatigue ☐ Tenderness in Breasts ☐ Acne ☐ Other
if so, how many days before period?________

Period: During your period do you suffer from:
☐ Cramping (Mark as appropriate)
☐ Severe ☐ Moderate ☐ Mild
☐ Before Period ☐ After Period ☐ During Period
At what age did it begin? _______________

Clotting : ☐ Bright in Color ☐ Dark in Color
☐ Before Period ☐ After Period ☐ During Period
Bleeding Between Periods ☐ If so how many days? __________ color: bright red ☐ brown ☐ crimson ☐ other ☐

Have you been diagnosed with:
☐ Endometriosis ☐ Yeast Infection/Vaginitis ☐ Ovarian Cysts ☐ Hot Flashes ☐ Breast Cysts
☐ PCOS ☐ 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?	Y	N	Pelvic Inflammatory Disease	Y	N
Uterine fibroids	Y	N	Polyps	Y	N
Pelvic adhesions	Y	N	Prolapsed uterus	Y	N
Endometriosis	Y	N	Unique shape of uterus	Y	N
PCOS	Y	N	Frequent bladder infections	Y	N

Have you been evaluated by and 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 used, how long, when did you stop, why?)
____
____
____

Do you have a pacemaker (circle one) Y N Do you have a bleeding condition? (circle one) Yes No
Do you have any infectious disease? Y N If yes please identify
Please list all known food or drug allergies ____
____
____

Please List all medications (prescriptions and over the counter) you are currently taking:

Name	Rx or OTC	How much, why?

Hospitalizations and Surgeries

What was done?	Date

Personal History (Please Indicate Self (X), Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF))

____ AIDS/HIV ____ Alcoholism ____ Anemia ____ Anxiety ____ Arthritis ____ Asthma ____ Back pain ____ Bursitis
____ Cancer ____ Chronic Pain ____ Chronic Fatigue____ Constipation ____ Depression ____ Diabetes
____ Diverticulitis / IBS____ Emphysema____ Food Allergies / Intolerance ____ Gastritis/Pancreatitis ____ Headaches
____ Heart Disease ____ Hepatitis ____ Hypertension____ Hypo/Hperglycemia ____ Impotence ____ Insomnia
____ Liver/Gallbladder Disease____ Lyme Disease____ Migraines____ Neck Pain____ Respiratory Allergies
____ Raynaud's ____ Seizures ____ Stroke____ Thyroid Imbalance

Do you participate in the following physical activities? If so, please indicate how often
Yoga:_________ Running:__________ Fitness classes:_________ Gym: _________
Biking: ________ Swimming:________ Walking: _______________ Other:________

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

What do you do to alleviate stress in your daily life? ____

____

____

Anything else we should know? ____

____

____

How did you hear about us? ____

Signature ___________________________ Date _________________________