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Reproductive Health History

Name: _____ Date: _____
Birth date: _____ Age: _____ Phone #: _____ Alternate #: _____
Address: _____
E-mail: _____
Signature: _____ Referred by: _____

Please fill out this history as carefully as possible. This information assists us in understanding your body and being of greatest benefit to you.

Health Concerns:

Gynecology:

I have been evaluated by a physician for the condition(s) being treated within the past 12 months: Y N

Name of OB/GYN: _____

Reproductive Endocrinologist: _____ Midwife: _____

May we share information with your other healthcare providers: Y N Initial: _____

Age of first menstrual cycle: _____

Date of first day of last menstrual cycle: _____

Are your cycles regular: Y N Cycle length: _____ (interval from start of one cycle to start of next)

Do you have any symptoms at time of ovulation: Y N (i.e. pain mid-cycle, increased cervical fluid)

Usual duration of blood flow is: _____ days

Amount of flow: light moderate heavy

Do you have clots: mild moderate severe (darker tissue in menstrual flow)

	<u>Preceding cycle</u>			<u>After onset of cycle</u>		
	Mild	Mod	Severe	Mild	Mod	Severe
Breast changes						
Irritability						
Fatigue						
Bowel changes						
Low back pain						
Cramps						

Last PAP: _____ Breast Exam: _____ Mammogram: _____

Low libido: Y N

Is intercourse painful: Y N

Mother's health while pregnant with you: poor fair good great don't know

Mother's age at menopause (if known): _____

Please check any current or past symptoms:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Headaches	___	___	Rapid weight change	___	___	Intolerance of heat	___	___
History of injury	___	___	BM less than 1x/day	___	___	Vaginal dryness	___	___
Visual problems	___	___	BM soft / loose	___	___	Intolerance of cold	___	___
Spots in front of eyes	___	___	Digestion problems	___	___	Wake to urinate	___	___
Dizziness	___	___	Change in appetite	___	___	Ringings in ears	___	___
Reduced concentration	___	___	Chronic Stress	___	___	Loss of scalp hair	___	___
Palpitations	___	___	Acne	___	___	Excess hair face/body	___	___
Anxiety	___	___	Depression	___	___	Discharge from nipples	___	___
Difficulty sleeping	___	___	Irritable/angry	___	___	Vaginal discharge	___	___
Excessive fatigue	___	___	Increased sweating	___	___	Difficulty swallowing	___	___

Fertility Assistance:

Length of time actively trying to conceive: _____ years _____ months

Tests taken:	Yes	No	Year	Normal	Abnormal	If yes, give dates/results
Temperature charts	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram (x-ray of tubes & uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy (looking inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-coital test (tests sperm in cervical mucus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy (looking inside abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 FSH	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Progesterone	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prolactine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lutinizing Hormone (LH)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosome tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____						

Please list any assisted reproduction procedures you have tried such as IUI (with or without medication) or IVF's:

Procedure:	Date:	Outcome:	Procedure:	Date:	Outcome: