Patient Health History for Fertility

Name:_____Date:_____
Address:_____
City, State, Zip code _____
Phones: Home_____Work:_____Cell:_____
Email address:_____
Date of Birth:_____ Age:_____
Occupation:_____
Emergency contact:_____
Ob/Gyn:_____
Current Medications:_____
_____
_____
What supplements do you currently take? _____
_____
_____
Do you have any implants/pacemaker?_____

Your partner:

Name: _____ Age:_____
Occupation:_____
Smoker? _____If so, how much _____
Coffee/sodas/day_____
Alcohol consumption/day:_____
Is your partner over or underweight?_____
How is his diet, generally?_____
Significant medical history:_____

Your Past Medical History

Check all that apply and indicate dates where applicable

___ Hepatitis ___ HIV / AIDS ___ Diabetes
___ Cancer ___ High Blood Pressure ___ Heart Disease
___ Surgery_____
Other significant medical condition:_____
Trauma/Accidents_____
Emotional trauma (divorce, etc):_____

Lifestyle

Do you exercise regularly?_____
Do you smoke? _____ If so, how much?_____
Do you drink alcohol? _____ If so, how much? _____
How much coffee/tea/soda do you drink per day?_____
How much water do your drink per day? _____
How often do you eat the following;
Vegetables_____ Candy_____ Dairy_____
Fruit _____ Red meat _____ Fast food _____
Refined carbs (bread, pastries, cake, chips, cookies, etc):
_____
Are you vegetarian?_____

Height_____ Weight _____
Recent change in weight?_____

Reproductive History

Age at first period_____
Are your periods regular or irregular?_____
Is your flow heavy or light _____
How many days does your period last?_____
How many days between periods?_____
Other vaginal discharge?_____
Do you experience any of the following symptoms before or during your period?

___ Abdominal cramps ___ Food cravings
___ Breast tenderness/swelling ___ Headaches/Migraines
___ Depression ___ Moodiness/Irritability
___ Dull pain ___ Sharp pain ___ Back ache

Number of pregnancies_____ Number of children_____
Number of abortions:_____
Number of miscarriages:_____ At what week:_____
Have you taken the pill? If so, when & for how long? _____
Has your partner had children?_____
Have you or your partner ever been diagnosed with an STD?_____
How long have you been trying to conceive?_____

Have you or you or your partner been given a diagnosis?_____
_____
Are you currently seeing a Reproductive Specialist (MD)? If so, who:
_____
What treatments have you tried/are you currently trying?_____
_____
_____
_____
_____
Have your hormone levels been checked?_____
Sperm analysis:_____
What other tests or procedures have you had? _____
_____
_____
_____

<u>Your General Health</u>

Body Temperature

___ Cold fingers	___ Feel hot all over	___Sweaty at night
___ Cold hands	___ Feel hot in afternoon	___ Thirsty at night
___ Cold arms	___ Feel hot in face	___ Hot flashes
___ Cold toes	___ Feel hot in hands	___ Sweat easily
___ Cold feet	___ Feel hot in feet	___ Lack of sweat
___ Cold legs	___ Feel feverish	___ Take water
___ Feel cold all over	___ Thirsty	to bed

Energy Level

___ Low energy ___ Low energy after exercise
___ Low energy at specific time of day. If so, when?_____

___ Shortness of breath	___ Sleepy during day	___ Lethargic
___ Reluctance to talk	___ Catch colds easily	___Fatigue

Circlulation/Blood

___ Dizzy ___ See floaters/spots ___ Numbness/tingling in extremities

Heart and Associated TCM Functions

___ Palpitations	___ Irregular heartbeat	___ Pacemaker
___ Insomnia	___ Poor sleep	___ Chest pain
___ Mental confusion	___ Sores on tip of tongue	___ Anxiety
___ Chest pain traveling to arm or shoulder		___ Restlessness

Lung and Associated TCM Functions

___ Nasal Discharge: Color_____ Thick or Thin____

___ Cough	___ Dry mouth	___ Dry skin
___ Nose bleeds	___ Dry throat	___ Fever & chills
___ Sinus congestion	___ Dry nose	___ Sneezing
___ Overall achy body	___ Stiff neck	___ Stiff shoulders
___ Sore throat	___ Difficulty breathing	___Feel sad
___ Allergies	___ Smoke cigarettes	___ Melancholy
___ Clear throat frequently	___ Sniffling/snorting	

___ Headaches. If so, where & how often_____

_____

Spleen and Associated TCM Functions

___ Low appetite	___ Abdominal gas	___ Hemorrhoids
___ Crave sweets	___ Gurgling stomach	___ Bruise easily
___ Abdominal bloating	___ Feel tired after eating	___ Nose bleeds
___ Worry	___ Over thinking	___ Pensive
___ Loose stools	___ Urgent BMs	___ Diarrhea
___ Discomfort after BM	___ Undigested food in stool	___ Weight gain
___ Blood in stool	___ Mucous in stool	___ Weight loss
___ Constipation	___ Dry lips	

Number of bowel movements per day (or per week)_____

___ General feeling of heaviness in body		___ Mental fogginess
___ Mental sluggishness	___ Nausea	___ Swelling
___ Vaginal discharge	___ Overweight	

Stomach and Associated TCM Functions

___ Heartburn	___ Mouth sores (canker sores)	
___ Pain after eating	___ Bleeding, painful or swollen gums	
___ Large appetite	___ Facial swelling/pain	___Nausea/Vomiting
___ Bad breath	___ Acne	___Acid regurgitation
___ Belching	___ Hiccups	___ Stomach pain

Liver/Gallbladder and Associated TCM Functions

___ Alternating diarrhea and constipation		___ High stress level
___ Bitter taste in mouth	___ Bad temper	___ Headaches
___ Anger easily	___ Irritable	___Heat in head/face
___ Frustration	___ Lump in throat	___ Muscle tension

___ Depression ___ Feel tense ___ Muscle twitches
___ Gall stones ___ High pitched ringing in ears
___ Discomfort/tightness/tension around ribcage ___ Itchy skin/rashes
___ Itch/pain genitals ___ Seizures/convulsions

Kidney and Associated TCM Functions

___ Low back pain/weakness
___ Cold sensation in low back
___ Wake at night to urinate
___ Bladder/Kidney/urinary infection
___ Lack of bladder control
___ Excessive hair loss/balding
___ Frequent broken bones
___ Libido: __Normal __High __ Low
___ Osteoporosis
___ Weak or sore knees
___ Cold sensation in knees
___ Kidney stones
___ Memory problems
___ Feel fearful
___ Easily startled
___ Frequent cavities
___ Kidney infections
___ Restless legs at night

Urination:

___ Normal color ___ Reddish ___ With blood
___ Dark yellow. If yes, do you take vitamins?_____
___ Clear ___ Cloudy ___Scanty
___ Profuse ___ Frequent ___ Strong odor
___ Painful ___ Dribbling ___ Urgent
___ Difficult Other_____

Any other comments: _____
_____
_____
_____
_____
_____
_____
_____

No one can listen to your body for you.
To heal, you have to listen to your body

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