Acupuncture and Chinese Herbal Medicine ▪ Complementary Reproductive Medicine

"Where the Wisdom of the East
Meets the Science of the West"

Name (Last, First, Middle)	Date

Age at which menses began _____

Are your periods painful? ☐Yes ☐No

How many days do you normally bleed? _____

How heavy is the bleeding? ☐Light ☐Normal ☐Heavy

What color is the blood? ☐Light red ☐Red ☐Dark red

☐Purple ☐Brown ☐Black

Is there clotting? ☐Yes ☐No

Does your face break out before or during your period? ☐Yes ☐No

Do your breasts become tender premenstrually? ☐Yes ☐No

Do you bleed or spot between periods? ☐Yes ☐No

Are your menstrual cycles spaced irregularly? ☐Yes ☐No

How many days are there from one period to the next? _____

Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D & C been performed?	_____	_____

Have you ever had an abnormal pap smear? ☐Yes ☐No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐Yes ☐No

Have you ever had a venereal disease? ☐Yes ☐No

Do you get yeast infections regularly? ☐Yes ☐No

Have you ever been diagnosed with a chlamydial infection? ☐Yes ☐No

Have you ever had pelvic inflammatory disease? ☐Yes ☐No

Were you treated for it? ☐Yes ☐No

How? _____

Date of last pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? ☐Yes ☐No

Have you ever been diagnosed with endometriosis? ☐Yes ☐No

Have you been diagnosed with pelvic adhesions? ☐Yes ☐No

Have you been diagnosed with any pelvic abnormalities? ☐Yes ☐No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long

Have your cycles changed since they began? ☐Yes ☐No

How? _____

Do you ovulate on your own? ☐Yes ☐No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? ☐Yes ☐No

Do you get premenstrual low back pain? ☐Yes ☐No

Do you have chronic vaginal discharge? ☐Yes ☐No

Do you have any sores on your genitalia? ☐Yes ☐No

Have you had fertility treatments? ☐Yes ☐No

If yes, when and where?_____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? ☐Yes ☐No

When? _____ How long? _____

Have your fallopian tubes been evaluated medically? ☐Yes ☐No

What were the results? _____

Have you had any tubal operations? ☐Yes ☐No

Have you had any hormone laboratory tests performed? ☐Yes ☐No

What were the results? _____

Do you have a single partner with whom you have been trying to conceive? ☐Yes ☐No

How long have you been married or living together? _____

Has he had a fertility workup? ☐Yes ☐No

What were the results? _____

Is your partner supportive of your wish to conceive? ☐Yes ☐No

Have you taken oral contraceptives? ☐Yes ☐No

When? _____ How long? _____

Have you ever had an IUD? ☐Yes ☐No

When? _____ How long? _____

Have you ever taken DepoProvera? ☐Yes ☐No

When? _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ☐Yes ☐No

What was it? _____

Do your bowel movements become loose at the beginning of your period? ☐Yes ☐No

How is your sexual energy? ☐Low ☐Normal ☐High

Do you douche regularly? ☐Yes ☐No

With what? _____

Do you use vaginal lubricants? ☐Yes ☐No

Are you more than 20% over your ideal body weight? ☐Yes ☐No

Are you more than 20% below your ideal body weight? ☐Yes ☐No

Do you have a stressful occupation? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Do you have excessive facial hair? ☐Yes ☐No

Do you have excessively oily skin? ☐Yes ☐No

Have you experienced excessive loss of head hair? ☐Yes ☐No

Have you noticed discharge from your nipples? ☐Yes ☐No

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

Have you been exposed to any known environmental toxins or hormones? ☐Yes ☐No

Are you presently taking steroids? ☐Yes ☐No

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent YES answers for more than one diagnostic category.

DIAGNOSIS

KIDNEY YIN DEFICIENCY (Ki Yi-)

Do you have lower back weakness, soreness, or pain, or knee problems?	☐Yes	☐No
Do you have ringing in your ears or dizziness?	☐Yes	☐No
Does your hair prematurely gray?	☐Yes	☐No
Do you have vaginal dryness?	☐Yes	☐No
Is your midcycle fertile cervical mucus scanty or missing?	☐Yes	☐No
Do you have dark circles around or under your eyes?	☐Yes	☐No
Do you have night sweats?	☐Yes	☐No
Are you prone to hot flashes?	☐Yes	☐No
Would you describe yourself as afraid a lot?	☐Yes	☐No
Does your tongue lack coating? Does it appear shiny or peeled?	☐Yes	☐No

DIAGNOSIS

KIDNEY YANG DEFICIENCY (Ki Yan-)

Do you have lower back premenstrually?	☐Yes	☐No
Is your low back sore or weak?	☐Yes	☐No
Are your feet cold, especially at night?	☐Yes	☐No
Are you typically colder than those around you?	☐Yes	☐No
Is your libido low?	☐Yes	☐No
Are you often fearful?	☐Yes	☐No
Do you wake up at night or early in the morning because you have to urinate?	☐Yes	☐No
Do you urinate frequently, and is the urine diluted and/or profuse?	☐Yes	☐No
Do you have early morning loose, urgent stools?	☐Yes	☐No
Do you have profuse vaginal discharge?	☐Yes	☐No
Does your menstrual blood tend to be dull in color?	☐Yes	☐No
Do you feel cold cramps during your period that respond to a heating pad?	☐Yes	☐No

Is your tongue pale, moist, and swollen? ☐Yes ☐No

DIAGNOSIS

SPLEEN QI DEFICIENCY (Sp-)

Are you often fatigued? ☐Yes ☐No

Do you have poor appetite? ☐Yes ☐No

Is you energy lower after a meal? ☐Yes ☐No

Do you feel bloated after eating? ☐Yes ☐No

Do you crave sweets? ☐Yes ☐No

Do you have loose stools, abdominal pain, or digestive problems? ☐Yes ☐No

Are you hands and feet cold? ☐Yes ☐No

Is your nose cold? ☐Yes ☐No

Are you prone to feeling heavy or sluggish? ☐Yes ☐No

Are you prone to feeling heaviness or grogginess in the head? ☐Yes ☐No

Do you bruise easily? ☐Yes ☐No

Do you think you have poor circulation? ☐Yes ☐No

Do you have varicose veins? ☐Yes ☐No

Are you lacking strength in your arms and legs? ☐Yes ☐No

Are you lacking in exercise? ☐Yes ☐No

Are you prone to worry? ☐Yes ☐No

Have you been diagnosed with low blood pressure? ☐Yes ☐No

Do you sweat a lot without exerting yourself? ☐Yes ☐No

Do you feel dizzy or light-headed, or have visual changes when you stand up fast? ☐Yes ☐No

Is your menstruation thin, watery, profuse or pinkish in color? ☐Yes ☐No

Are you more tired around ovulation or menstruation? ☐Yes ☐No

Do you ever spot a few days or more before your period comes? ☐Yes ☐No

Have you ever been diagnosed with uterine prolapse? ☐Yes ☐No

Are your menstrual cramps accompanied by a bearing-down sensation in your uterus? ☐Yes ☐No

Are you often sick, or do you have allergies? ☐Yes ☐No

Have you been diagnosed with hypothyroid or anemia? ☐Yes ☐No

Do you have hemorrhoids or polyps? ☐Yes ☐No

Does your tongue look swollen, with teeth marks on the sides? ☐Yes ☐No

Do you have a pale, yellowish complexion? ☐Yes ☐No

DIAGNOSIS

BLOOD DEFICIENCY (BI-) (*not necessarily equated with anemia*)

Are your menses scanty and/or late? ☐Yes ☐No

Do you have dry, flaky skin? ☐Yes ☐No

Are you prone to getting chapped lips? ☐Yes ☐No

Are your fingernails or toenails brittle? ☐Yes ☐No

Are you losing hair on your head (not in patches, but all over)? ☐Yes ☐No

Is your hair brittle or dry? ☐Yes ☐No

Do you have diminished nighttime vision? ☐Yes ☐No

Do you get dizzy or light-headed around your period? ☐Yes ☐No

Are your lips, the inner side of your lower eyelids, or tongue pale in color? ☐Yes ☐No

DIAGNOSIS

BLOOD STASIS (BI X) (*often associated with blood deficiency symptoms; see BI-*)

Is your menstrual flow ever brown or black in color? ☐Yes ☐No

Do you feel midcycle pain around your ovaries? ☐Yes ☐No

Do you have painful, unmovable breast lumps? ☐Yes ☐No

Do you experience periodic numbness of your hands and feet (especially at night)? ☐Yes ☐No

Do you have varicose or spider veins? ☐Yes ☐No

Do you have red hemangiomas (cherry red spots) on your skin? ☐Yes ☐No

Does your complexion appear dark and "sooty"? ☐Yes ☐No

Do you have chronic hemorrhoids? ☐Yes ☐No

Does your menstrual blood contain clots? ☐Yes ☐No

Have you been diagnosed with endometriosis or uterine fibroids? ☐Yes ☐No

Is your lower abdomen tender to palpation (resisting touch)? ☐Yes ☐No

Can you feel any abnormal lumps in your lower abdomen? ☐Yes ☐No

Do you have piercing or stabbing menstrual cramps? ☐Yes ☐No

Do you seem low in spirit or lacking in vitality? ☐Yes ☐No

Are you prone to agitation or extreme restlessness? ☐Yes ☐No

Do you fidget? ☐Yes ☐No

Is the tip of your tongue red? ☐Yes ☐No

Is there a crack in the center of your tongue that extends to the tip? ☐Yes ☐No

Do you sweat excessively, especially on your chest? ☐Yes ☐No

DIAGNOSIS

EXCESS HEAT (^H)

Is your pulse rate rapid? ☐Yes ☐No

Is your mouth and throat usually dry? ☐Yes ☐No

Are you thirsty for cold drinks most of the time? ☐Yes ☐No

Do you often feel warmer than those around you? ☐Yes ☐No

Do you wake up sweating or have hot flashes? ☐Yes ☐No

Do you break out with red acne (especially premenstrually)? ☐Yes ☐No

Do you have a short menstrual cycle? ☐Yes ☐No

Do you have vaginal irritation or rashes? ☐Yes ☐No

DIAGNOSIS

DAMPNESS (D)

Do you feel tired and sluggish after a meal? ☐Yes ☐No

Do you have fibrocystic breasts? ☐Yes ☐No

Do you have cystic or pustular acne? ☐Yes ☐No

Do you have urgent, bright, or foul-smelling stools? ☐Yes ☐No

Does your menstrual blood contain stringy tissue or mucus? ☐Yes ☐No

Are you prone to yeast infections and vaginal itching? ☐Yes ☐No

Do your joints ache, especially with movement? ☐Yes ☐No

Are you overweight? ☐Yes ☐No

Do you have a wet, slimy tongue? ☐Yes ☐No

Does your tongue look dark? ☐Yes ☐No

Do you have dark spots on your tongue? ☐Yes ☐No

Are the veins beneath your tongue twisty and tortuous? ☐Yes ☐No

Do you have dark spots in your eyes? ☐Yes ☐No

Have you been diagnosed with any vascular abnormality or blood clotting disorder? ☐Yes ☐No

DIAGNOSIS

LIVER QI STAGNATION (Lv Qi X)

Are you prone to emotional depression? ☐Yes ☐No

Are you prone to anger and/or rage? ☐Yes ☐No

Do you become irritable premenstrually? ☐Yes ☐No

Do you feel bloated or irritable around ovulation? ☐Yes ☐No

Does it feel as if your ovulation lasts longer than it should? ☐Yes ☐No

Are your breasts sensitive/sore at ovulation? ☐Yes ☐No

Do you experience nipple pain or discharge from your nipples? ☐Yes ☐No

Do you have a lot of premenstrual breast distension or pain? ☐Yes ☐No

Have you been diagnosed with elevated prolactin levels? ☐Yes ☐No

Do you become bloated premenstrually? ☐Yes ☐No

Are your pupils usually dilated and large? ☐Yes ☐No

Do you have difficulty falling asleep at night? ☐Yes ☐No

Do you experience heartburn or wake up with a bitter taste in your mouth? ☐Yes ☐No

Are your menses painful? ☐Yes ☐No

Do you feel your menstrual cramps in the external genital area? ☐Yes ☐No

Is your menstrual blood thick and dark, or purplish in color? ☐Yes ☐No

Is your tongue dark or purplish in color? ☐Yes ☐No

DIAGNOSIS

HEART DEFICIENCY (Ht-) (*often associated with heat*)

Do you wake up early in the morning and have trouble getting back to sleep? ☐Yes ☐No

Do you have heart palpitations, especially when anxious? ☐Yes ☐No

Do you have nightmares? ☐Yes ☐No

DIAGNOSIS

DAMP HEAT (DH)

Do you have signs of heat and/or dampness as indicated above? ☐Yes ☐No

Do you have foul-smelling, yellow, or greenish vaginal discharge? ☐Yes ☐No

Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? ☐Yes ☐No

DIAGNOSIS

COLD UTERUS (CW)

Do you fit the Kidney Yang deficiency (Ki Yan-) category? ☐Yes ☐No

Do you fall into the Blood stasis pattern? ☐Yes ☐No

Does your lower abdomen feel cooler to the touch than the rest of your trunk? ☐Yes ☐No

PATIENT _____ MONTH(S) _____ YEAR _____

Cycle Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Date																																				
Day of Week																																				
Intercourse																																				
Time Temp Taken																																				

Waking Temperature

Cycle Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Saliva Ferning																																				
Cervical Fluid																																				
OPK																																				
Ovulatory Pain																																				

Miscellaneous

Cramps																																				
Bloated																																				
Headaches																																				
Sore Breasts																																				
Emotional																																				
Other																																				
Other																																				

Male Fertility Form

CONFIDENTIAL

Date	First Name	Last Name	Middle Initial
____/____/____			

Gender M F	Date of Birth ____/____/____	Age	Body Type	Height:	Weight:	Complexion:	Occupation

Name of your doctor/ Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU
Other OBGYN doctor _____ Start Date: _____ Month/ Year

Western Diagnosis _____

1. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

2. Do we have a copy of your Semen Analysis? **Y / N**

3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / ASA	Others

4. Do you take any of these Supplements and/or Vitamins?

# of Months on Vitamins	Male Vitamins	Mega Man	Fish Oil	L - Carrnatine	L - Arganine	Antioxidants	EWA Complete List

Other: _____

_____

_____

5. Couples ART Plans:

IUI	Clomid	IVF	PGD	TESA	Other

6. Has the patient fathered children Y / N **If so, how many** _____

7. Male Health

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

8. Male Health Continued

Antisperm Antibodies	Sperm Chromatid / DNA Integrity	High Cholesterol	Diabetes (fasting, glucose)	Others
Y / N	Y / N	Y / N	Y / N	

9. Is your Spouse currently being treated by us? **Y / N**

10. Spouse's Name _____

11. Western Diagnosis of Spouse _____