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Women's Health and Fertility Intake Form

Tabor Village Wellness

404 SE 80th Ave • Portland, OR 97215 • (503) 335.3201

Name: _____ Date of Birth: _____ Date: _____

Gynecological/Reproductive history

Attempting Pregnancy currently? _____ If so, for how long? _____

Currently Pregnant If so, how far along _____ Currently breastfeeding If so, how long? _____

Difficult scanty or painful lactation _____

Post-partum difficulties _____

Describe _____

Premature deliveries _____ Difficult deliveries _____

Describe _____

Difficulties in Pregnancy

Describe _____

Age of first menses _____ What was it like for you? _____

Date of last menses _____ Recent menstrual changes If so, what? _____

How many days do you normally bleed? _____ How many days between periods? _____

How heavy is the bleeding? Heavy Average Light How many pads/tampons per day? _____

What color is the blood? Pale red, Pink, Red, Dark red, Purple, Brown, Black

Is the blood Watery, Clotted, Mucousy, Thick, Stringy, Have an odor?

Painful periods If so, how many days does pain last? _____ What makes the pain better? _____

Heaviness or pressure in pelvis with periods? Yes No

Have you ever gone more than 2 months without getting your period? When? _____

PMS What symptoms? _____ When do they start? _____

Bleeding/Spotting between periods? If yes, when in cycle _____

Do you ovulate regularly? _____ If so, on what day of your cycle? _____ Is ovulation painful? _____

Do you observe cervical mucus changes with ovulation? _____ Bleeding with ovulation? _____

Do any of your symptoms seem to change or worsen around your period? How? _____

Menopausal Symptoms:

Describe _____

Sleep

How long do you normally sleep? _____ hours per night

I have difficulties with (check all that apply): _____ Falling asleep _____ Staying asleep _____ Dream-disturbed sleep

_____ Waking up at about _____ am/pm and not being able to fall back asleep

Emotional Health

Have you ever been treated for a psychological concern? Yes No

Have you experienced sexual or physical abuse? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

Please rate your overall stress level: Low Medium High

Are you currently working with a counselor? If so, who? _____

If possible, please describe the most challenging emotion you experience _____

When do you most often feel this emotion? _____

What experiences or activities bring you the most joy and nourishment? _____

Do you have a spiritual practice? _____

What goals do you have for your acupuncture or naturopathic treatments? _____

Comments- please describe anything else you would like to discuss. _____

Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to complete this form.

Fertility Clinic _____

Physician _____

Western Medical Diagnosis (if any) _____

Western Diagnostic Tests & Hormone Panels (include dates & results)

θ Hysterosalpingogram (HSG) _____

θ Endometrial Biopsy _____

θ Clomid Challenge test _____

θ Follicle Stimulating Hormone (FSH) _____

θ Luteinizing Hormone (LH) _____

θ Estradiol (estrogen) _____

θ Progesterone _____

θ Prolactin _____

θ Doppler ultrasound (blood flow) _____

θ Hysteroscopy/Saline Infused Sonogram _____

θ Any additional tests _____

GYN related surgeries (dates & outcome):

A.R.T. History:

Intrauterine Insemination (IUI) Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

In Vitro Fertilization (IVF) Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

Male Factor (please include dates, results and any applicable treatment)

θ Sperm Count (#/cc) _____

θ Sperm Motility (% moving) _____

θ Sperm Morphology _____

θ Sperm Rise (“swim up test”) _____

θ Anti-sperm Antibodies _____

θ Varicocele (including surgery) _____

θ Sperm penetration assay (SPA) _____

θ Other male factor concerns _____

Other Past Treatments Please indicate any other forms of past treatment, both conventional and alternative.

Do you have any other comments, concerns, or issues that you would like to discuss?