Angela Bell Acupuncture
ACUPUNCTURE FOR WOMEN

Angela Bell Acupuncture
186 Alewife Brook Parkway, Suite 302
Cambridge, MA 02138

FEMALE FERTILITY INTAKE FORM

Patient Name:	**Date:**
Address:	
City: State:	Zip:
Phone:	
Email:	Date of Birth:
Emergency Contact:	Contact Phone:
How did you hear about me?	
Age:	
Current weight:	
Date of Last Period:	
Are you part of a heterosexual or same sex relationship?	

Medications / Vitamins / Supplements
Please list all over-the-counter medications, vitamins and/or supplements you currently take including any herbal medicines.

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Fertility History Summary	
Have you ever had a miscarriage? If so, when? And at what week in the pregnancy did you miscarry?	
Have you ever had an ectopic pregnancy? If so, when? And how was the ectopic pregnancy treated?	
Have you ever had ovulation medically induced with medication? If so, when? And which medication was used?	
If you were prescribed Clomid or Letrozole, was there a medical reason? In other words, did your doctor know or suspect that you were not ovulating naturally?	
Have you ever had an IUI? If so, when? And, what was the result?	
Have you ever completed an IVF Cycle? If so, when? And, what was the result?	

In the long narrow table on the right of this page, please list how long your menstrual cycles are from month to month (i.e. do you have 28 day cycles, 34 day cycles, etc.) Next to the number of days in your cycle list at which cycle day you typically ovulate (i.e. CD 14, CD16, etc)

Blood Test Results	Result	Date of Test
Follicle Stimulating Hormone (FSH)		
Estradiol		
Luteinizing Hormone (LH)		
Progesterone		
Prolactin		
Clomid Challenge Test (CCCT)		

Days in Cycle	Cycle Day you ovulate

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Fertility Evaluation	
How many months have you been trying to conceive?	
Have you been tracking ovulation and/or cervical mucus? If so, for how long?	
Number of pregnancies and/or number of live births?	
Please list any gynecological diagnosis you have received i.e. endometriosis, pelvic infections, ovarian cysts, PCOS, an- ovulation, etc.	
Please list any surgeries or over-night hospital stays:	
Cups of coffee or other caffeinated beverages/day?	
Alcoholic beverages/day?	
Have you been using temperature charts?	
If yes, for how many months?	
Have you been using ovulation predictor kits?	
Have you ever tried to achieve a pregnancy with a different partner?	
Have you ever conceived with a different partner?	
If you have a male partner, has he ever gotten someone else pregnant?	
Have you ever had Intrauterine inseminations (IUI)? If so, for how many cycles?	
If yes, specimen was provided by:	Partner or Donor
Have you ever attempted in vitro fertilization? If yes, please describe the outcome.	

Obstetrical History	
Have you ever been pregnant (including elective terminations, miscarriages, births?	

Gynecological History	
How old were you when you had you first period?	
How frequently do your periods come?	
How long do your periods last?	
Do you experience cramping with your periods?	
If yes, when during your cycles do you have pain?	Before / During / After
How would you describe the cramps?	Mild / Moderate / Severe
Do you take pain medication for the cramps? If yes, how much?	
Do you bleed or spot between periods?	
Have you ever had an abnormal Pap smear result?	
If yes, what therapy was required : Cryotherapy(freezing of cervix), Laser therapy, Cone biopsy LEEP Other: _____	
Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix. uterus, ovaries)? Chlamydia Trichomonas Gonorrhea Herpes Genital warts	
If yes, when and what treatment did you receive?	
Do you have pain with intercourse?	
If yes, does the pain remain in your lower abdomen after intercourse if over ?	
How frequently do you and your partner have intercourse?	
How frequently do you and your partner have intercourse around ovulation?	

Gynecological History	
Do you usually use lubrication during intercourse? If yes, please list specific products:	
Have you experienced any difficulties with intercourse that may be contributing to infertility? If yes, please explain:	
What types of contraception have you used in the past?	

Kidney Deficiency/Yin	Yes	No
Do you have low back weakness, soreness, pain or knee problems?		
Do you have ringing in the ears or dizziness?		
Is your hair prematurely gray?		
Do you have vaginal dryness?		
Is your mid-cycle cervical mucus scanty or non-existent?		
Do you have dark circles around your eyes?		
Do you urinate frequently?		
Do you have night sweats?		
Are you prone to hot flashes?		
Are you fearful often?		

Kidney Deficiency/Yang	Yes	No
Do you have lower back pain, especially before your period?		
Is your lower back sore or weak?		
Are your feet cold, especially at night?		
Are you typically colder by nature than those around you?		
Do you have a low libido?		
Are you fearful often?		

Kidney Deficiency/Yang	Yes	No
Do you wake wake up at night or in the early morning because you have to urinate? How many times?		
Do you urinate frequently and is the urine dilute and/or profuse?		
Do you have early morning loose or urgent stools?		
Do you have profuse vaginal discharge?		
Does your menstrual blood tend to be dull in color?		

Blood Deficiency	Yes	No
Do your periods tend to me light, scanty or late?		
Do you have dry, flaky skin?		
Are you prone to getting chapped lips?		
Are your fingernails or toenails brittle?		
Do you have problems with thinning hair?		
Is your hair brittle or dry?		
Do you have poor night vision?		
Do you get dizzy or lightheaded around your period?		
Are your lips, inside your lower eyelids or tongue, pale in color?		

Dampness	Yes	No
Do you feel tired and sluggish after a meal?		
Do you have fibrocystic breasts?		
Do you have cystic or pustular acne?		
Do you have urgent or foul smelling stools?		
Does your menstrual blood contain stringy tissue or mucus?		
Are you prone to yeast infections and vaginal itching?		
Do your joints ache?		
Are you overweight?		

Blood Stasis	Yes	No
Is your menstrual flow ever brown or black in color?		
Do you feel mid-cycle pain around your ovaries?		
Do you have painful, unmovable breast lumps?		
Do you experience periodic numbness of your hands and feet?		
Do you have varicose or spider veins?		
Do you have any red spots on your skin?		
Does your complexion appear dark or sooty?		
Do you have chronic hemorrhoids?		
Does your menstrual blood contain clots?		
Have you been diagnosed with endometriosis or uterine fibroids?		
Is your lower abdomen tender to palpate?		
Can you feel any abnormal lumps in your lower abdomen?		
Do you have piercing or stabbing menstrual cramps?		
Do you see dark spots in your eyes?		
Have you been diagnosed with any vascular abnormality or blood clotting disorder?		

Spleen Deficiency	Yes	No
Are you often fatigued?		
Do you have a poor appetite?		
Is your energy lower after a meal?		
Do you feel bloated after a eating?		
Do you crave sweets?		
Do you have loose stools, abdominal pain or digestive problems?		
Are you hands and feet usually cold?		
Are you prone to feeling heavy or sluggish?		
Do you often feel foggy headed or a heaviness in the head?		
Do you bruise easily?		
Do you have poor circulation?		
Do you have varicose veins?		
Do your arms and legs lack strength or feel heavy?		
Are you prone to worry?		
Have you been diagnosed with low blood pressure?		
Do you sweat easily without exertion?		
Do you feel lightheaded or have visual changes when you stand quickly?		
Is your menstruation thin, watery or pinkish in color?		
Are you more tired around ovulation or menstruation?		
Do you ever spot a few days prior to menstruation?		
Have you ever been diagnosed with uterine prolapsed?		
Do you have a bearing down sensation with menstrual cramps?		
Are you often sick or do you have allergies?		
Have you been diagnosed with hypothyroidism or anemia?		
Have you had hemorrhoids or polyps?		
Do you have a pale, yellowish complexion?		

Liver Qi Stagnation	Yes	No
Are you prone to emotional depression?		
Are you prone to anger or rage?		
Do you become irritable premenstrually?		
Do you feel irritable around ovulation?		
Does it feel like your ovulation lasts longer than it should?		
Are your breasts sensitive or sore at ovulation?		
Do you experience nipple pain or discharge from your nipples?		
Do you have a lot of premenstrual breast distention or pain?		
Have you been diagnosed with elevated prolactin levels?		
Do you become bloated premenstrually?		
Are your pupils usually dilated?		
Do you have difficulty falling asleep at night?		
Do you experience heartburn or wake with a bitter taste in your mouth?		
Are your menses painful?		
Do you feel your menstrual cramps in the external genitalia?		
Is the menstrual blood thick and dark or purplish in color?		

Damp Heat	Yes	No
Do you have foul smelling, yellow or greenish vaginal discharge?		
Are you prone to vaginal and or rectal itching during the luteal or premenstrual phase?		

Excess Heat	Yes	No
Does your pulse rate feel rapid?		
Are your mouth and throat usually dry?		
Are you thirsty most of the time?		
Do you crave icy, cold drinks?		
Do you often feel warmer than those around you?		
Do you wake up sweating?		
Do you break out with red acne (especially premenstrually?)		
Do you have a short menstrual cycle?		
Do you have vaginal irritation or rashes?		

Heart Deficiency	Yes	No
Do you wake up early in the morning and can't fall back asleep?		
Do you get heart palpitations especially when anxious?		
Do you have nightmares?		
Do you seem low in spirit or lacking in vitality?		
Are you prone to agitation or extreme restlessness?		
Do you fidget a lot?		
Is the tip of your tongue red?		

Please describe any other details you feel are relevant to your menstrual cycle, gynecological health and/or your ability to conceive.

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