Northwoods Acupuncture & Wellness Center

(612) 600-5761

Infertility Patient History Form

All information provided is held strictly confidential. This form will not be released to a third party without your consent.

Today's Date

IDENTIFYING INFORMATION

Name

Birth Date

Age

Name of Significant Other

Birth Date

Age

Number of years together

Primary Care MD

How long have you been attempting conception?

Primary GYN

Marital Status

Reasons for your visit:

RACE (you)

- ☐ Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ Asian
- ☐ African American
- ☐ Other

(significant other)

- ☐ Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ Asian
- ☐ African American
- ☐ Other

PREGNANCY HISTORY

Pregnancies # Term Births # High Risk Pregnancies # Difficult Labor/deliveries

Premature Births # Miscarriages # Elective Abortion # Postpartum concerns

Lactation concerns # Adopted Children

Date	Miscarriage	Elective Abortion	Ectopic	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complications	Is current partner the father?

CONTRACEPTIVE USE

Type	From when to when	Reason discontinued

MENSTRUAL/HORMONAL

Last Pap Smear _____ Last Mammogram _____

Pelvic pain/cramps:

☐ none ☐ during menses ☐ before menses ☐ after menses ☐ at midcycle ☐ during intercourse
☐ with urination ☐ with bowel movements ☐ cause you to miss work ☐ cause you to miss usual activities

Pelvic pain/cramps are::

☐ mild ☐ moderate ☐ severe ☐ worsening ☐ improving ☐ no change
☐ in midline ☐ on right side ☐ on left side

Frequency of Intercourse _____

Do you have or have you had? (check all that apply)

- ☐ Hot flushes
- ☐ Breast discharge
- ☐ Visual disturbance
- ☐ Poor sense of smell
- ☐ Chronic headache
- ☐ Head trauma
- ☐ Increased facial or body hair
- ☐ Increased acne
- ☐ Weight increase > 10 pounds
- ☐ Weight loss > 10 pounds
- ☐ Special dietary habits
- ☐ Vomiting
- ☐ Seizures
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Autoimmune disease
- ☐ Extraordinary stress
- ☐ Psychiatric treatment

If "yes" to any of the above, please explain:

GYNECOLOGIC / INFECTION

Do you have or have you had? (check all that apply)

- ☐ Pelvic infection
- ☐ Chlamydia
- ☐ Endometriosis
- ☐ Pelvic adhesions
- ☐ Cervicitis
- ☐ Genital herpes
- ☐ Appendicitis
- ☐ Colitis or enteritis
- ☐ Uterine fibroids or myomas
- ☐ Abnormal uterus shape
- ☐ Recurrent vaginitis
- ☐ Abnormal Pap smears
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Mycoplasma
- ☐ Ureaplasma
- ☐ Genital warts / condyloma
- ☐ Cryo (freezing) or surgery of the cervix
- ☐ Ovarian cysts
- ☐ Toxoplasmosis
- ☐ Cytomegalovirus (CMV)
- ☐ Tuberculosis
- ☐ Trichomonas

EXTERNAL INFLUENCES

Your Occupation _____ Spouse's Occupation _____

Cigarettes (how many per day) _____ Alcohol (type and # each week _____

Marijuana (amount) _____ Other drugs (type & amount) _____

Caffeine drinks/day _____ Electric blanket use _____ Ever used intravenous drugs? _____

Computer hours/day _____ Radiation Exposure _____ Hot tub or sauna use _____

GENETIC HISTORY

Do you, your partner, or anyone in either family have any of the following inherited disorders? (check all that apply)

- ☐ Neural tube defects/spina bifida/anencephaly
- ☐ Thalassemia
- ☐ Down syndrome
- ☐ Cystic fibrosis
- ☐ Muscular dystrophy
- ☐ Mental retardation/ fragile X
- ☐ Tay-Sachs disease
- ☐ Sickle cell disease or trait
- ☐ Hemophilia
- ☐ Hormonal disorder
- ☐ Chromosomal disorder
- ☐ Baby with birth devects
- ☐ Infertility
- ☐ Huntington chorea

If you checked any of the boxes above, please explain for each:

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility previously? If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? (please check all that apply)

- ☐ Clomid (Serophene)
- ☐ hCG Profasi
- ☐ Antibiotics
- ☐ Gonal F
- ☐ Progesterone
- ☐ Baby aspirin
- ☐ Follistim
- ☐ Lupron
- ☐ Heparin
- ☐ Repronex
- ☐ Microdose Lupron
- ☐ Steroids
- ☐ Pergonal
- ☐ Antagon
- ☐ Oral Contraceptives
- ☐ Fertinex
- ☐ Parlodel
- ☐ Other

Please list: