AcuBalance
Acupuncture & Integrative Medicine

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Reproductive & Fertility Questionnaire

This Questionnaire is kept strictly confidential. We understand that fertility and reproductive history is personal; we are committed to providing an atmosphere that is respectful, nonjudgmental, and compassionate.

Name:_____ Age: _____ Date: _____

Menstrual Cycle

Age of First Menses: _____ Length of Cycle _____ Days of Menstruation _____

Last Menstrual Period _____ to _____

Flow/Days: Heavy _____ Normal_____ Light_____ Clots: Yes No

Color: Light Red Red Dark Red Purple Brown Black

Other Info: _____

Do you ovulate on your own? On What Day? _____

How is your cervical mucous production throughout? _____

Date of last PAP _____ Date of last Mammogram _____

Have you ever had an abnormal Pap or Mammogram? _____

Please answer Yes/No for chronic history of or current Premenstrual Symptoms

Do you have PMS	Yes	No	Do you spot between periods?	Yes	No
Do you have hormonal acne?	Yes	No	Do your breasts become tender?	Yes	No
Are your periods painful	Yes	No	Is your period timing irregular?	Yes	No
Days of pain, location etc._____					
Do you become irritable?	Yes	No	Do you have appetite changes?	Yes	No
Do you have loose stool?	Yes	No	Do you have cravings?	Yes	No
Do you get lower back pain?	Yes	No	Ovulation Pain (cramps, breast)	Yes	No

Please answer Yes/No for chronic history of or current OB-GYN Conditions

Yeast Infections	Yes	No	Urinary Tract Infections	Yes	No
Chronic Vaginal Discharge	Yes	No	STD or Veneral Disease	Yes	No
Pelvic Inflammatory Disease	Yes	No	Uterine Fibroids or Polyps	Yes	No
Pelvic Adhesions	Yes	No	Blocked Fallopian Tubes	Yes	No
Endometriosis	Yes	No	Polycystic Ovarian Syndrome	Yes	No
Stage _____			(PCOS)		
Abnormal Nipple Discharge	Yes	No	Fibrocystic Breasts	Yes	No

Other _____

Please write about any contraceptive use (pill, DepoProvera, IUD, etc):_____

_____

Fertility History

How long have you been trying to conceive? _____

Any information regarding previous pregnancies or miscarriage: _____

_____

Have you taken medication to help you ovulate? _____

Have your fallopian tubes been examined? _____

Have you had any tubal operations? _____

Have you had any laboratory work? _____

_____

Please use this space to describe fertility treatments sought so far (Meds, IUI, IVF etc) _____

_____

_____

_____

Please use this space to list your current OB-GYN medications or supplements

Medication	**Reason**	**Length Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since you began medication? _____

_____

Lifestyle Questions

How is your sexual energy? Low Normal High Do you use lubricant? Yes No

How often do you have intercourse? _____

Any Other Thoughts, Comments: _____

_____

_____

_____

_____

_____