Bradenton Community Acupuncture Women's Health Intake

For any women interested in fertility acupuncture and/or women's health acupuncture, please fill out this form *in addition to* the regular intake form.

Patient Name (Last, First) _____ Date _____

Gynecological History

Date of last pap smear? _____

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 chlamydial infection? Yes ____ No ____

Do you have chronic vaginal discharge? Yes ____ No ____

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

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

Were you treated for it? Yes ____ No ____

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

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

If yes, when? _____ Were you treated for it? Yes ____ No ____

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

Have you been diagnose with any pelvic abnormalities? Yes ____ No ____

Have you taken medications for gynecological conditions other than contraceptives? Yes ____ No ____

If yes, please list below. If you need additional room, please use the back of this form.

Medication (including dose)	**Reason**	**How long**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? Yes ____ No _____

If yes, how so? _____

Menstruation History

Age in which menses began _____

Date of last menstrual cycle _____

Have you gone through menopause? Yes ____ No ____

If yes, please describe any menopausal symptoms (if yes, after answering, please skip to 'Past Pregnancies' section) _____

Do you experience pain with your period? Yes ____ No ____

How long does the pain last? _____ Where is the pain_____

How many days do you typically bleed? _____

How heavy is your cycle? (*Please check one)* Light ____Normal ____ Heavy ____

What color is your blood? (*Please check one)*

Light Red ____ Red ____ Dark Red ____ Purple ____ Brown _____ Black _____

Do you have clotting with your cycle? Yes ____ No ____

Do you have premenstrual tension? Yes ____ No ____

Does your skin break out before &/or during your cycle? Yes ____ No ____

Do you have breast tenderness before &/or during your cycle? Yes ____ No ____

Do you experience bleeding or spotting between cycles? Yes ____ No ____

Are your menstrual cycles spaced irregularly? Yes ____ No ____

How many days are there from the beginning of one cycle to the next? _____

Past Pregnancies

How many pregnancies have you had? _____

How many times have you given birth? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Fertility History

How long have you been trying to conceive? _____

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

If yes, please explain _____

Do you ovulate on your own? Yes ____ No _____

If yes, on which day of your cycle (typically)? _____

How do you track ovulation? _____

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

Do you get premenstrual lower back pain? Yes ____ No ____

Do your bowel movements loosen at the beginning of your cycle? Yes ____ No ____

Have you had fertility treatments? Yes ____ No ____

If yes, when did you receive treatment(s)? _____

Which practice(s)? _____

What type(s)? _____

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 tubal operations? Yes ____ No ____

If yes, when? _____

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

What were the results? _____

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

How long have you been together & trying to conceive? _____

Has he had a fertility work up? Yes ____ No ____

If yes, what were the results? _____

Have you taken oral contraceptives? Yes ____ No ____

When? _____ How long? _____ Which kind(s)? _____

Have you ever had an IUD? Yes ____ No ____

When? _____ How long? _____

Have you ever taken Depo Provera? Yes ____ No ____

When? _____ How long? _____

Sexual History

How is your sexual energy? (*Please check one)* Low ____ Normal ____ High ____

Do you douche regularly? Yes ____ No ____

If yes, with what? _____

Do you use vaginal lubricants? Yes ____ No ____

If yes, what kind? _____

Do you have a stressful occupation/lifestyle? Yes ____ No ____

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

Do you exercise regularly? Yes ____ No ____

If yes, please describe: _____

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 _____

Please provide any additional comments on the back of this form