Classical Acupuncture Clinic

Fertility Health History

Please complete this health history. Indicate test results, dates and tests and any side effects due to medications. All information will be kept strictly confidential.

Name:____________________________________Age:______ Date:_______________
Fertility Clinic:____
Physicians:____
____
____
____

Western Medical Diagnostic Test and Hormone Panels:

Hysterosalpingogram (HSP): Y N Results:__________________________Test Date:_________

Endometrial Biopsy: Y N Results:_________________________________Test Date:_________

Clomid Challenge: Y N Results:____________________________________Test Date:_________

Follicle Stimulating Hormone (FSH): Y N Results:_______________________Test Date:_________

Leutinizing Hormone (LH): Y N Results:______________________________Test Date:_________

Estradiol: Y N Results:_________________________________Test Date:_________

Progesterone: Y N Results:_________________________________Test Date:_________

Prolactin: Y N Results:_________________________________Test Date:_________

Any additional tests:

Gyn-related surgeries: (include dates and results):____
____
____

Male partner information:

Has your partner completed screening tests? Y N Results:_______________Test Date:_________

Is your partner currently being treated? Y N How? ____________________Results:_____________

Is your partner willing to consider treatment? Y N

Western Medical Diagnostic Tests:

Sperm Motility: Y N Results:__________________________Test Date:_________

Sperm Morphology: Y N Results:__________________________Test Date:_________

Sperm Count: Y N Results:__________________________Test Date:_________

Male only:

Erectile dysfunction: Y N How long?____________

Circle one: Always Often Sometimes Here and there

What makes it worse?____

What makes it better?____

Inability to reach orgasm: Y N

Circle one: Always Often Sometimes Here and there

What makes it worse?____

What makes it better?____

Lowered libido: Y N

Circle one: Always Often Sometimes Here and there

What makes it worse?____

What makes it better?____

Women:

Assisted Reproductive Therapy

Please indicate procedures, dates of procedures, medications, any side effects, quality and quantity of eggs produced, size of eggs, number of cells and results.

IUI:____
____
____
____
____

IVF:____
____
____
____
____

Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT):________________

____
____
____

Please indicate any other treatments, conventional and alternative:_________________________

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____

Please indicate any other information you think is important for me to know:___________________

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Signature:_______________________________________Date:__________________