Female Infertility Form

Referring Doctor: ______ Date:__/_____/ 201__

Name: (First) ________________ (Middle) ___ (Last) ______________________
Date of Birth (MM/DD/YY) ___/___/___ Age___ Occupation ____
Address:______________________________ City: ___________ State: ____ ZIP: _____
Home Phone: ( ) ________ Cell Phone: ( ) _________ Work Phone: ( )_____________
Email: ______________________ [ ] I agree to receive the notice or information by E-Mail

FEMALE MEDICAL HISTORY AND INFORMATION

- Reason for Visit: ☐ Evaluation ☐ Herb formula ☐ Acupuncture ☐ Other_______
- How many months have you been trying to conceive? _____
- Have you previously conceived with other men?
  ☐Yes: How many times?_____ ☐No: Birth control used? Yes___ No___
- Have any of your immediate family members had difficulty conceiving a child? ☐Yes: How many of them?_____ ☐No
- What's your plan for infertility in next one year?
  ☐ By natural way: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
  ☐ By IUI: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
  ☐ By IVF: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
  ☐ Other :______________________________

What infertility problems have been diagnosed already? *If yes, please check on the box.*

☐ Hormone level (FSH, E2….) ____________________________
☐ Pelvic adhesions ____________________________
☐ Endometriosis ____________________________
☐ Hostile cervical mucus ____________________________
☐ Uterine fibroids ____________________________
☐ Blocked or damaged tubes ____________________________
☐ Irregular or absent ovulation ____________________________
☐ Corpus luteal defect ____________________________
☐ Other ____________________________

Prior Tests: *If yes, please check on the box.*

Test	Date	Results
☐ Basal body temperature chart:	____/____	____________________
☐ Thyroid test	____/____	____________________
☐ Ovulation test kit	____/____	____________________
☐ Day 3 blood test for FSH level	____/____	____________________
☐ Ultrasound	____/____	____________________
☐ Semen Analysis	____/____	____________________
☐ Hysterosalpingogram (HSG)	____/____	____________________
☐ Hormonal blood tests	____/____	____________________
☐ Laparoscopy	____/____	____________________
☐ Hysteroscopy surgery	____/____	____________________
☐ Progesterone blood test	____/____	____________________
☐ Prolactin blood test	____/____	____________________
☐ Laparoscopy surgery	____/____	____________________
☐ Endometrial biopsy	____/____	____________________
☐ Post–Coital test (PK)	____/____	____________________

Prior Treatment: *If yes, please check on the box.*

☐ Daily fertility drug injections with insemination: #__From__/__ to__/__Max tablets per day?___
☐ Canceled in vitro fertilization attempt(s) #_____, Reason:_________________
☐ Intrauterine insemination: #_____ From_____/_____ to_____/_____
☐ Clomiphene citrate with timed intercourse: #__From__/__ to__/__Max# tablets per day?_____
☐ Clomiphene citrate with insemination:: #__From__/__ to__/__Max# tablets per day?_____

☐ Completed in vitro fertilization cycle(s) : # ____________
☐ Embryos transferred: # ____________
eggs#___ , embryos transferred# ___, ___/___ ; Pregnancy ☐ Yes ☐ No
eggs#___ , embryos transferred# ___ , ___/___ ; Pregnancy ☐ Yes ☐ No
eggs#___ , embryos transferred# ___ , ___/___ ; Pregnancy ☐ Yes ☐ No

☐ Frozen embryo transfers: # ____________
embryos transferred: #_____, _____/_____ ; Pregnancy ☐ Yes ☐ No
embryos transferred: #_____, _____/_____ ; Pregnancy ☐ Yes ☐ No
embryos transferred: #_____, _____/_____ ; Pregnancy ☐ Yes ☐ No
☐ Other ____________________

Pregnancy Summary: *If yes, please check "x" on the box.*

- Total Number of ALL Pregnancies: _____
- Pregnancies with current partner ☐ Yes ☐ No
- Number of Full Term Deliveries: ____ , Live births# ___ , Stillborn # ___
- Number of Premature(< = 37 weeks) Deliveries: _, Live births# _, Stillborn# _
- Number of Miscarriages (less than 20 weeks): _____ , ___________
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- Any Pregnancies with Birth Defects? ☐No ☐Yes :_______________
- Difficulty conceiving? ☐ No ☐ Yes:__________________

Menstrual cycle History: *If yes, please check "x" on the box.*

☐Regular periods ☐Irregular periods ☐No periods ☐Spotting before periods ☐Spotting after periods ☐Heavy periods ☐Light periods ☐Bleeding between periods ☐Change in menstrual periods ☐Worsening menstrual cramps ☐Cramps several days before period ☐Scanty or infrequent period ☐Other_____

- Days between the start of one period to the start of the next period: ___days
- How many days of bleeding do you have? _____days
- Blood clot size: ☐<1 cm ☐1-2cm ☐>2 cm
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- Age when you had your first period: _____years old
- How many periods do you have per year? _____
- Do you take medication to bring on a period? ☐No ☐Yes, type?________________
- If you do not have periods, when did you stop period? _____ years old
- Severe cramping or pain with your periods? ☐No ☐Yes: Always__ Sometimes ______

Sexual History: *If yes, please check "x" on the box.*

- **Sexual** : ☐Pain with intercourse ☐Bleeding after intercourse ☐Sexual problems ☐Lubrication used with intercourse ☐Douche after intercourse
- **Contraceptive** ☐Birth control pills - dates of use______ ☐Never used birth control pills ☐Inject able contraception - dates of use__ ☐Skin patch - dates of use___ ☐Foam or Jelly

- How many times do you have intercourse per week? _____times per week ☐None
- Have you used over-the-counter ovulation kits to time intercourse? ☐Yes ☐No
- Do you have pain with intercourse? ☐Yes ☐No
- Do you use lubricants during intercourse? ☐No ☐Yes
- Age at first intercourse: _____years old
- Number of sexual partners for pass 3 - 5 years: _____
- Sexually Transmitted Diseases Chlamydia ☐Gonorrhea ☐Genital warts ☐Syphilis ☐HIV ☐other__

Medical History: *If yes, please check "x" on the box.*
☐ Allergic to any medications: ______________________________
☐ Allergic to any foods: ___________________________
☐ Taking medication: ___________________________
☐ Herbal medicines/ supplements: _________________
☐ Any medical problem(s)? (type, dates, treatments): ______________
☐ Any surgeries? Year____ Reason ____ Type of Surgery _______

Physical Symptoms: *If yes, please check "x" on the box.*

General:
☐Acne problem ☐Excessive hair growth anywhere ☐ Alcohol / Drug addition ☐Hepatitis/HIV ☐Depression ☐Recent weight gain or loss ☐Dizziness ☐Loss of sense of smell ☐Shortness of breath ☐Anorexia/Bulimia ☐Headaches ☐Chronic nasal congestion ☐Asthma ☐Bronchitis ☐Lack of energy ☐Blurred vision ☐Ringing ears ☐Pneumonia ☐Tuberculosis ☐Fever/Chills ☐Hearing loss/deafness ☐Bloody cough ☐Other_

Endocrine/Hormonal/ Breasts/Neurological Problems:
☐Diabetes ☐Hair loss ☐Breast Discharge (clear, bloody, milky)______ ☐Breast Pain ☐Thyroid gland problems ☐Lumps ☐Cancer ☐Seizures/Epilepsy ☐Abnormal mammogram ☐Excessive hunger/thirst ☐Migraine headaches ☐Temperature intolerance ☐Augmentation/Breast implants ☐hot flashes or feeling cold ☐Memory loss ☐Other________

Gastrointestinal/Genito-Urinary/Skin:
☐Nausea/Vomiting ☐Ulcers ☐Bladder infections ☐Hepatitis ☐Diarrhea ☐Kidney infections ☐Blood in your stools ☐Constipation ☐Vaginal infections ☐Irritable Bowel Syndrome ☐Frequent urination ☐Leaking urine ☐Burn injury ☐Change in bowel habits ☐Colitis ☐Blood in the urine ☐Excess hair growth ☐Acne ☐Skin rash/inflammation ☐Skin cancer ☐Herpes ☐Moles changing in appearance ☐Other________

Musculoskeletal/ Hematologic/Cardiovascular:
☐Unusual muscle weakness ☐Blood clotting disorder/Blood clot ☐Palpitations/Skipped beats ☐Decreased energy/stamina ☐Sickle cell Anemia ☐Thrombophlebitis ☐Chest pain ☐Heart attack ☐Rheumatoid arthritis ☐Easy bruising ☐Stroke ☐Murmurs ☐Lupus Erythematosus ☐Swollen glands/lymph nodes ☐High blood pressure ☐ Myasthenia gravis ☐Blood transfusions ☐Rheumatic fever ☐Other______________________

Mental Health Problems:
☐ Depression ☐ Anxiety disorder ☐ Schizophrenia ☐ Other______________________
☐ Do you see a counselor? ___________________
☐ Any emotional, marital, or sexual problems caused by your infertility. ________________
• Scale stress (1-10, 10 is the best emotion) due to infertility # ______

Diet: What percentage of your diet:

Vegetables___	Fruits___	Whole grains___	Beans/legumes___
Red meat___	Fish___	Poultry___	Dairy___
White flour(bread, pasta)___	Sugary Foods	Chips/ snacks___	/ Fast food___

Habits

- ☐ Caffeinated beverages (coffee, tea, soda), How many/day?_____
- ☐ Cigarettes? How many/day?_____ ☐ Quit - when?______________
- ☐ Beer - # per week_____ ☐ Wine- # per week_____ ☐ Liquor - # per week_____
- ☐ Marijuana, cocaine,....? ______________
- ☐ Exercise? (Min/per day, type), ___________________________
- ☐ Any radiation exposures other than X-rays? _______________

TCM Diagnosis : MALE / FEMALE Name :___________

* *If yes, please check "x" on the box.*

General Body Temperature	☐ Cold ☐ Cool ☐ Temperate ☐ Warm ☐ Hot	☐ Hot, High Fever, Sensitive To Heat ☐ Low Grade Fever in the Palm ☐ Cold, Sensitive To Cold ☐ Very Cold, Sensitive To Cold ☐ Other ____
HEAD AND BODY	☐ Headaches ☐ Dizziness ☐ Chest pain	☐ Poor Hearing ☐ Tinnitus ☐ Earaches ☐ Other ____
General	☐ Insufficient lactation ☐ Dizziness/vertigo ☐ Feel warm in afternoon ☐ Feel warm in evening ☐ Dry skin, hair, nails ☐ Hot flashes ☐ Flushed face ☐ Night sweats	☐ Deep heat in body or feet ☐ Low grade fever in PM ☐ Blurred or weak vision ☐ Heat in palm of hands ☐ Thirsty for cold drinks ☐ Numbness/tingling in hands ☐ Other ____
Energy	☐ Tired, fatigued ☐ Extreme fatigue ☐ Tired after exercising	☐ Spontaneous sweating ☐ Cold sweats ☐ Wake up and feel tired ☐ Other ____
Tongue color Fur	☐ Pink/Light Red Body ☐ Red Body ☐ Red Body ☐ Pale Body ☐ Purplish/Bluish Body ☐ Flaccid Body	☐ Thin Coat ☐ White Coat ☐ Yellow Coat ☐ Thin/No Coat ☐ Thick Coat ☐ Green Coat ☐ Other ____
Face	☐ Red ☐ Pale ☐ Only Cheeks Red	☐ Dark at some area ☐ Yellow at some area ☐ Other ____
Eyes	☐ Red ☐ Yellow ☐ Dark Circles ☐ Spots in front of eyes ☐ Poor vision	☐ Edema around eyes ☐ Blurry vision ☐ Eyestrain ☐ Dry ☐ Burning ☐ Other ____
Skin	☐ Red, Inflamed ☐ Dry skin ☐ Oily skin, body odor ☐ Spontaneous Sweat ☐ Rashes	☐ Changes in skin texture ☐ Psoriasis ☐ Boils/Cysts ☐ Acne ☐ Warts

	☐ Itching ☐ Ulcerations ☐ Eczema ☐ Hives ☐ Dandruff	☐ Color changes ☐ New/changed moles ☐ Lumps ☐ Other ____
Hair	☐ Hair loss ☐ Grey hair	☐ Changes in hair texture ☐ Other ____
Lungs	☐ Weak Cough ☐ Feeble cough ☐ Dry cough ☐ Productive cough ☐ Dry throat ☐ Catch colds easily ☐ Afternoon fever ☐ Post-nasal drip ☐ Chest congestion	☐ Profuse thick white/clear phlegm ☐ Shortness of breath, difficulty breathing ☐ Shortness of breath with exertion ☐ Difficulty breathing lying down ☐ Strong/loud cough w/phlegm ☐ Sinus discharge ☐ Sinus infections ☐ wheezing ☐ Other ____
Heart	☐ Rapid/weak Beat ☐ Weak heart ☐ Palpitation ☐ Cold limbs ☐ Blue lips	☐ Low functional energy ☐ Very rapid/strong beat ☐ Very poor blood circulation ☐ Other ____
Appetite Digestion	☐ High ☐ Very low appetite ☐ Cravings ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Gas ☐ Bloating	☐ Hungry, but can not eat ☐ No energy to eat ☐ Food preferences ☐ Weak/slow digestion ☐ Heartburn ☐ Bad breath ☐ Other ____
Thirst	☐ High thirst ☐ Likes cold drinks ☐ Likes hot drinks ☐ Dry mouth	☐ Might/might not have low thirst. ☐ Low thirst, likes warm water. ☐ Thirsty with desire to drink ☐ Thirsty with no desire to drink ☐ Other ____
Liver	☐ Calm/relaxed ☐ Depressive ☐ Anxious ☐ Angry ☐ Irritable ☐ Stressed ☐ Grief ☐ Over thinking ☐ Fearful ☐ Depression ☐ Breast distension	☐ Bitter taste in mouth ☐ Foreign body sensation in throat ☐ Dysmenorrhea ☐ Numbness of limbs ☐ Muscle twitches ☐ Spasms of tendons ☐ Dry brittle nails ☐ Poor night vision ☐ Floaters/spots in vision ☐ Tremor, shaking ☐ Nail changes

	☐ Dizziness ☐ Flushed face ☐ Nightmares	☐ Scanty yellow urine ☐ Other ____
Stool	☐ Dry hard stool ☐ Sticky stool w/mucus,	☐ Get constipated or have diarrhea ☐ Number of bowel movements per day: ☐ Other ____
Spleen	☐ Nausea ☐ Weight gain ☐ General fatigue ☐ Prefer warm food ☐ Bloating after eating ☐ Tired after eating ☐ Weakness in limbs ☐ Chilly with cold limbs ☐ Poor appetite	☐ Aversion to greasy food ☐ Loose stool with undigested food ☐ Bleed/bruise easily ☐ Heavy menstrual bleeding ☐ Prolapsed organs ☐ Hemorrhoids ☐ Loose stools/diarrhea ☐ Other ____
Bladder	☐ Any pain or difficulty with either urination or defecation? ☐ undigested food, mucous, or blood in the stool? ☐ cloudy ☐ Other ____	☐ Dark, scant, yellow urine, Inflammation (UTI). ☐ Scant, light yellow urine, low grade UTI ☐ Copious urination, light/whitish Colored ☐ Copious, clear, frequent, usually night urination Color of the urine ☐ Clear, ☐ Yellow, ☐ Dark
Kidney	☐ Low back dull pain ☐ Knee pain ☐ Clear urine ☐ Impotence ☐ Dental problems ☐ Asthma ☐ Insomnia ☐ Tinnitus ☐ Dizziness ☐ Poor memory	☐ Frequent urination at night ☐ Bone fractures, weakness ☐ Loose stool with undigested food ☐ Difficulty inhaling a deep breath ☐ Diarrhea in early morning ☐ Night sweats/hot flashes ☐ Low back/knee pain ☐ Frequent urination ☐ Swollen ankles, legs ☐ Other ____
Reproduction	☐ Yeast, infections, cysts. ☐ Low sex drive, can't Perform	☐ Strong/excess sex drive ☐ Slightly higher sex drive, but tires easily ☐ Other ____
Menses	☐ Normal ,regular, no PMS, no cramps, no clots ☐ Short cycle ☐ Dark red ☐ Bright red ☐ Brown ☐ Scanty	☐ Dark purplish, long period or no period ☐ Long cycle, thin, light colored, delayed menstruation ☐ Clots in your period Size: ___cm ☐ Odour smell ☐ Other___
Sleep	☐ Very good	#___Hours of sleep per night

	☐ Good ☐ Bad ☐ Very bad ☐ Restless, low quality ☐ Wants To sleep a lot	☐ Likes to take naps, feels better after sleep ☐ Trouble falling asleep, symptoms worse at night ☐ Wants to sleep, groggy after sleep ☐ Frequently dream or nightmares ☐ Other ____
Energy	☐ Often feel tired ☐ Weak ☐ True weakness	☐ High level of energy, restless ☐ Exhausted. tired, cannot sleep ☐ Other ____
Emotions	☐ Sad, depressed ☐ No motivation ☐ Self esteem ☐ Angry and anxious	☐ Clinical, mental, neurological disorders ☐ Angry, anxious, agitated ☐ Less energy behind the emotion ☐ Restless all the time ☐ Other ____
Speech	☐ Loud, rapid, talks a Lot ☐ Speaks quickly ☐ Nnot loud or strong	☐ Heavy Voice ☐ Slow and weak speech ☐ Mainly "yes" or no Answers ☐ Other ____
Dampness Phlegm	☐ Sweaty hands/feet ☐ Ear discharge ☐ Nodules ☐ Cysts	☐ Foggy/sluggish thinking ☐ Difficulty getting up in morning ☐ Headaches like a band around the head ☐ Other ____

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ITEM Name **ITEM Number #**	**Description**	**Unit**	**Unit price**	**Qty**	**Total**
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Payment: We accept Visa, Master cards and money order in US funds enclosed.
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Shipping & Delivery: Order will be shipped by UPS ground or USPS Priority Mail. When payment is confirmed, Please allow 7 - 10 days to process and deliver the herbs.
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Informed Consent: I understand that some herbs may be inappropriate during pregnancy. Therefore, I will notify the traditional Chinese medicine practitioner who are caring for me if I am or become pregnant. I do not expect the traditional Chinese medicine practitioner to be able to anticipate and explain all risks and complications of treatment.
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Signature: X_______________ Name(Print): ____________________ , Date: __ / __ /__