Japanese Acupuncture Clinic

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Fertility Questionnaire

Name

Email Address

Phone Number

How long have you been trying to conceive? Please list the number of months / years:

Were you on birth control pills for many years?

- ◯ no
- ◯ yes (list number of years)

What has the length of your menstrual cycle been during the last 3 months?

- ◯ less than 25 days
- ◯ 28 days
- ◯ 30 days or longer
- ◯ irregular

How many days do you usually bleed (not counting spotting)?

- ◯ less than 3 days
- ◯ 5 days
- ◯ more than 5 days
- ◯ irregular

Does your partner have any infertility issues? If so, describe:

Are you aware of when you are ovulating? Do you have any signs of ovulation?

Do you keep a Basal Body Temperature (BBT) chart?

- ◯ no
- ◯ yes

Are you aware of your **cervical mucus** and the quality?

- ☐ thick like glue & yellow
- ☐ egg white / stretchy
- ☐ watery clear
- ☐ dry
- ☐ not sure

Do you notice your cervical mucus secretion a couple of days before ovulation?

- ◯ no
- ◯ yes
- ◯ not sure

Do you have excessive facial hair and/or oily skin?

- ◯ no
- ◯ yes

What is your color of blood when you menstruate? Dark brown or dark red in color?

Do you often have mid-cycle pain around your ovaries (one-sided pain)?

- ◯ no
- ◯ yes

Do you suffer from PMS symptoms?

- ☐ pimples on the face
- ☐ irritability
- ☐ headache
- ☐ cramps
- ☐ low back pain
- ☐ breast pain
- ☐ other symptoms

Do you have a cramp on the left lower abdominal area on the 1st day of your period?

- ◯ no
- ◯ yes

Do you take any pain medication like Motrin or Advil during your menstrual cycle?

- ◯ no
- ◯ yes

Do you pass dime or quarter sized dark purple **clots** on the 1st or 2nd day of your menstrual cycle?

- ◯ no
- ◯ yes

Do you have varicose or spider veins?

- ◯ no
- ◯ yes

Do you suffer from chronic hemorrhoids?

- ◯ no
- ◯ yes

Have you ever been tested for endometriosis?

- ◯ no
- ◯ yes

Have you ever been diagnosed with uterine fibroids?

- ◯ no
- ◯ yes

Do you feel bloated or irritable around ovulation?

- ◯ no
- ◯ yes

Have you been diagnosed with elevated prolactin levels?

- ◯ no
- ◯ yes

Do you have difficulty falling asleep at night?

- ◯ no
- ◯ yes

Do you suffer from migraine headaches or pain behind the eyes or eyebrows?

- ◯ no
- ◯ yes

Do you often have a pain between the scapula (shoulder wing) and the spine on one side?

- ◯ no
- ◯ yes

Do you often wake up between 1-3AM and are unable to go back to sleep?

- ◯ no
- ◯ yes

Do you experience heartburn after you eat meat?

- ◯ no
- ◯ yes

Do you experience a bitter taste in your mouth?

- ◯ no
- ◯ yes

Do you have foul-smelling, yellow, or greenish vaginal discharge?

- ◯ no
- ◯ yes

Are you prone to yeast infections and vaginal and/or rectal itching during your luteal or premenstrual phase?

- ◯ no
- ◯ yes

Do you notice **your feet are always cold,** even in the summer time?

- ◯ no
- ◯ yes

Do you wear a pair of socks when you sleep?

- ◯ no
- ◯ yes
- ◯ sometimes

Do you have profuse vaginal discharge when you are NOT ovulating?

- ◯ no
- ◯ yes

Do you urinate frequently? For example, you need to go to the bathroom within 30 min. after drinking a glass of water.

- ◯ no
- ◯ yes

Do you notice that your urine is diluted and profuse?

- ◯ no
- ◯ yes

Do you have **vaginal dryness, unlubricated**?

- ◯ no
- ◯ yes

Do you have tinnitus (ringing in ears)? Does it sound like ocean waves? A cricket sound? Or a high-pitched noise?

- ◯ no
- ◯ yes

Do you suffer from lightheadedness (dizziness) or vertigo (ceiling is spinning)?

- ◯ no
- ◯ yes

Do you have night sweats or are you prone to hot flashes? And when? During the day, eve or night?

- ◯ no
- ◯ yes (specify when) _____

Do you have dark circles around or under your eyes that have been getting darker over the last couple of years?

- ◯ no
- ◯ yes

Is your cervical mucus during ovulation (mid-cycle) scanty or missing?

- ◯ no
- ◯ yes

Do you often feel tired and have a **strong desire to take a nap around 2-3-4PM**, regardless of what you eat for lunch?

- ◯ no
- ◯ yes

Is your energy lower after a meal?

- ◯ no
- ◯ yes

Do you experience spotting before or after your period?

- ◯ no
- ◯ yes (enter number of days) _____

Do you bruise easily?

- ◯ no
- ◯ yes

Have you been diagnosed with low blood pressure?

- ◯ no
- ◯ yes

Are you often tired and tend to catch cold easier than other people?

- ◯ no
- ◯ yes

Are your menses scanty and/or late?

- ◯ no
- ◯ yes

Do you have dry, flaky skin?

- ◯ no
- ◯ yes

Are you prone to getting chapped lips?

- ◯ no
- ◯ yes

Are your fingernails and toenails brittle? Do they have vertical ridges? White dots?

- ☐ brittle nails
- ☐ vertical ridges
- ☐ white dots

Do you have a difficulty driving at night?

- ◯ no
- ◯ yes

Do you often have vivid dreams?

- ◯ no
- ◯ yes

Do you have heart palpitations, especially when anxious?

- ◯ no
- ◯ yes

Please take a look at your tongue. Is the tip of your tongue red/purple in color?

- ◯ no
- ◯ yes

Is there a crack in the center of your tongue that extends to the tip?

- ◯ yes
- ◯ no

Do you wake up early in the morning (4-5AM) and have trouble getting back to sleep?

- ◯ no
- ◯ yes

Are your mouth and throat dry and thirsty for cold drinks most of the time?

- ◯ no
- ◯ yes

Do you often feel warmer than those around you?

- ◯ no
- ◯ yes

Do you have a short menstrual cycle?

- ◯ no
- ◯ yes

Do you have vaginal irritation or rashes?

- ◯ no
- ◯ yes

Do you eat wheat on a regular basis? Example: Bagel for breakfast, sandwich for lunch, a dinner roll, pasta, and dessert at dinner time.

- ◯ no
- ◯ yes

Does your prenatal vitamin contain Folic Acid or Folate? Do you know the difference?

- ◯ Folic Acid
- ◯ Folate
- ◯ I don't know

Do you tend to crave bread & pasta, sweets, or salt?

- ☐ bread & pasta
- ☐ sweets
- ☐ salt

Do you eat dairy products* like cheese, yogurt, milk and ice cream on a regular basis?
** Dairy from cow, not from goat, soy, coconut*

- ◯ no
- ◯ yes

Do you have difficulty digesting meat – especially beef?

- ◯ no
- ◯ yes

Do you eat cruciferous vegetables like kale, collard greens, swiss chard and broccoli every day?

- ◯ no
- ◯ yes

How many glasses of water do you drink a day?

Do you drink soft drinks on a regular basis? Soft drinks include Gatorade, Powerade, Squirt, Fresca, Fanta Orange, Mountain Dew, etc.

- ◯ no
- ◯ yes

Do you use artificial sweetener? Artificial sweeteners include Sweet'N Low, Splenda, Equal, Truvia, agave nectar, etc.

- ◯ no
- ◯ yes

Do you take a daily Calcium supplement? If yes, are you taking a Calcium Carbonate form of Calcium?

- ◯ no
- ◯ yes (enter Calcium Carbonate or not) _____

Do you take a daily Magnesium supplement? If yes, what kind of Magnesium and dosage?

- ◯ no
- ◯ yes (enter type and dosage) _____

Do you take a Zinc supplement? If yes, what kind of Zinc and dosage?

- ◯ no
- ◯ yes (enter type and dosage) _____

Do you take a daily Vitamin D supplement? If yes, what kind of B12 and dosage?

- ◯ no
- ◯ yes (enter type and dosage) _____

Do you think lemons and limes are an acidic food or an alkaline food*?
** check this chart: http://www.angelfire.com/az/sthurston/acid_alkaline_foods_list.html*

- ◯ acidic
- ◯ alkaline

Have you been diagnosed with low progesterone levels?

- ◯ no
- ◯ yes

Do you take Synthroid or Levothyroxine? If yes, have your symptoms improved by taking these medications?

- ◯ no
- ◯ yes, symptoms have improved
- ◯ yes, but symptoms have NOT improved

Have you tested positive for thyroid antibodies* (Anti-thyroid peroxidase (Anti-TPO) and Thyroglobulin (TgAb))?
**see http://thyroid.about.com/cs/basics_starthere/a/antibody.htm*

- ◯ no
- ◯ yes

Do you have any autoimmune diseases? AIED-autoimmune inner ear disease, Meniere's disease, rheumatoid arthritis, psoriasis, plantar fasciitis, hypothyroidism, Hashimoto's disease, Raynaud's phenomenon (cold and red fingers and toes), lupus, Graves' disease (eye disease), Behcet's disease, chronic fatigue syndrome, fibromyalgia, Crohn's disease, type 1 diabetes, ulcerative colitis, pernicious anemia (B12 deficiency), Guillain-Barre syndrome, Celiac disease (muscle disorder), mononucleosis, Harada's syndrome (eye disease), Epstein-Barr virus, MS, etc.)

- ◯ no
- ◯ yes

Fertility Treatment History

Please take the time to fill out this history form as carefully as possible.

Fertility Clinic

Physician

Western Medical Diagnosis

Western Diagnostic Tests & Hormone Panels (includes dates & results):

Hysterosalpingogram (HSP)

Endometrial Biopsy

Clomid Challenge

Follicle Stimulating Hormone Level (FSH)

Leutinizing Hormone Level (LH)

Estradiol Level (E2)

Progesterone Level

Prolactin Level

Any additional Tests

GYN Related Procedures and Surgeries (dates & outcome):

If past treatment has included any IUI/IVF, please indicate dates, medications, and its dosages, length of stimulation, your body's response (number of eggs, quality, cells, unwanted side effects) and the results.:

Male Factor

Sperm Count - fewer than 20 million sperm per milliliter of semen?

- ◯ no
- ◯ yes

Sperm Motility (% moving)

Sperm Morphology

Varicocele (swelling of the veins that drain the testicle) problem

- ◯ no
- ◯ yes

Anti-Sperm Antibodies (common in men who’ve had a vasectomy)

- ◯ no
- ◯ yes

Chromosome Defects (genetic / inherited disorder)

- ◯ no
- ◯ yes

Sperm Duct Defects (usually damaged by illness or injury)

- ◯ no
- ◯ yes

Long Term Medication (Steroid, Chemo, Antibiotics, Ulcer, Testosterone)

- ◯ no
- ◯ yes

Hormone Imbalance (Low Testosterone for example)

- ◯ no
- ◯ yes

Celiac Disease (Sensitivity to gluten – wheat products)

- ◯ no
- ◯ yes

Undescended Testicles (Occurred during fetal development)

- ◯ no
- ◯ yes

Tumors (Cancers, and nonmalignant tumors)

- ◯ no
- ◯ yes

Retrograde Ejaculation (Semen enters the bladder)

- ◯ no
- ◯ yes