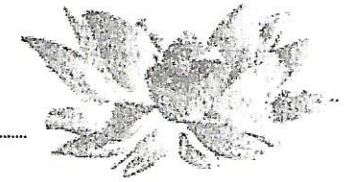
Fertility Patient Intake Form



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Name: _____ Date: _____

Please answer all questions as best as you can. If you do not understand or cannot answer a question, leave it blank.

1. What is the purpose of your visit today? (check one)
   ☐ Adjunct to assisted reproductive technology →*go to next question*
   ☐ Preparation for pregnancy without medical intervention → *skip to question 7*

2. You are preparing for:
   ☐ Natural Cycle (unassisted)
   ☐ IUI
   ☐ IVF Estimated date of procedure: _____
   ☐ IVF Donor Egg Cycle
   ☐ FET / Frozen Embryo Transfer

3. Is this your first attempt? ☐ Yes ☐ No→ how many? IVF_____ IUI_____

4. Your attending physician/reproductive endocrinologist: _____
   Hospital: _____

5. Your infertility diagnosis is: _____
   _____

6. List the drugs/medications you will be taking in preparation for the procedure.

NAME:	DOSE:	DATE(S)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Answer question 7 ONLY if you are <u>not</u> using assisted reproductive technology.

7. Have you had an infertility diagnosis? ☐ Yes ☐ No
   If yes, what was the diagnosis? _____
   _____
   _____

8. How long have you been trying to get pregnant? _____

9. Has your partner had his reproductive status evaluated by a physician? ☐ Yes ☐ No
   If yes, what problems were found? _____

10. Have you had failed attempts with reproductive technology? ☐ Yes ☐ No
    If yes, how many times? _____ When? _____

11. Have your FSH levels been evaluated? ☐ Yes ☐ No
    If yes, what were they? _____

12. Have you used drugs from a doctor for fertility purposes? ☐ Yes ☐ No
    If yes, pleas list:

NAME:	DOSE:	DATE(S)

13. Have you ever become pregnant naturally? ☐ Yes ☐ No
    If yes, how many times? _____ With this partner? ☐ Yes ☐ No

    Live births: _____

    Miscarriages: _____ How far along into the pregnancy? _____

14. Premenstrual symptoms:

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a. Headache					
b. Diarrhea/ loose stool					
c. Constipation					
d. Acne					
e. Night sweats					
f. Irritability					
g. Bloating					
h. Nausea					
i. Coldness					
j. Abdominal pain					
k. Low back ache					
l. Yeast					
m. Herpes outbreaks					
n. Itching					
o. Vaginal sores or eruptions					
p. Fatigue					

15. How many days between menstrual cycles typically (Day 1 to Day 1)? _____

16. Do you have pain around the time of ovulation? ☐ Yes ☐ No

17. What day in your cycle do you think you ovulate? _____
    Has this been confirmed through a BBT chart? ☐ Yes ☐ No
    Monitor? ☐ Yes ☐ No

18. How many days is the cycle? _____

19. In the last 12 months, the cycle has gotten:
    ☐ Longer ☐ Shorter ☐ Unchanged

20. In the last few cycles, the amount of bleeding has been:
    ☐ More ☐ Less ☐ Unchanged

21. Bleeding begins:
    ☐ Red ☐ Brown

22. Describe color and consistency of menstruate and flow:

    _____

    _____

23. Check all that apply:

    ☐ Clotting Large ☐ Clotting Small ☐ Bearing down sensation
    ☐Red ☐Thin red, like water ☐ Brown/black
    ☐ Flow starts and stops
    ☐ Other comments: _____

24. Do you have problems with vaginal dryness? ☐ Yes ☐ No

25. Do you notice stretchy cervical mucous around ovulation? ☐ Yes ☐ No

26. Libido (check one)

1 Low	2	3	4	5	6	7	8	9	10 High

HISTORY OF:

☐ Fibroids
☐ Ovarian hyperstimulation
☐ Endometriosis
☐ Ovarian cysts
☐ Tubal pregnancy
☐ Fetal genetic abnormalities
☐ PID (pelvic inflammatory disease)
☐ POF (premature ovarian failure)
☐ PCOS (polycystic ovarian disease)
☐ Thyroid
☐ Uterine anatomical abnormalities
☐ Pelvic adhesions
☐ Antiphospholipid antibodies
☐ Thin uterine lining
☐ Diagnosis of hostile cervical mucous
☐ Abnormal progesterone level
☐ Oral contraceptive use, if yes, # of years: _____ When did you stop? _____
☐ "Poor responder" to fertility drugs, if yes, which ones and when? _____

Past procedures:

☐ HSG/test for blocked tubes, if yes are tubes open? ☐ Yes ☐ No
☐ Midcycle vaginal ultrasound, if yes – results: _____
☐ Abortion(s)

	YES	NO	SOMETIMES
A. (Ki Yin Xu)			
1. Do you have low back weakness, soreness, pain, or knee problems?			
2. Do you have ringing in your ears?			
3. Is your hair prematurely gray?			
4. Do you have vaginal dryness?			
5. Is your midcycle fertile cervical mucus slight or missing?			
6. Do you have dark circles around or under your eyes?			
7. Are you prone to hot flushes?			
8. Do you have night sweats?			
9. Would you describe yourself as being afraid frequently?			
10. Does your tongue lack coating?			
11. Does your tongue appear shiny or peeled?			
B. (Ki Yang Xu)			
1. Do you have lower back pain premenstrually?			
2. Is your lower back sore or weak?			
3. Are your feet cold, especially at night?			
4. Are you typically colder than those around you?			
5. Is your sex drive low?			
6. Are you often fearful?			
7. Does the need to urinate wake you up through the night or in the morning?			
8. Do you urinate frequently and is the urine diluted and/or profuse?			
9. Do you have early morning loose or urgent bowel movements?			
10. Do you have profuse vaginal discharge?			
11. Does your menstrual blood tend to be dull in color?			
12. Do you feel cold cramps during your period that respond to a heating pad?			
13. Is your tongue pale, moist, or swollen?			

	YES	NO	SOMETIMES
C. (SP Qi Xu) 1. Are you often fatigued?			
2. Do you have a poor appetite?			
3. Does your energy go down after a meal?			
4. Do you feel bloated after eating?			
5. Do you crave sweets?			
6. Do you have abdominal pain?			
7. Do you have loose stool or digestive problems?			
8. Are your hands and feet cold?			
9. Is your nose cold?			
10. Are you prone to feeling heavy or sluggish?			
11. Are you feeling groggy or heaviness in the head?			
12. Do you bruise easily?			
13. Do you think you have poor circulation?			
14. Do you have varicose veins?			
15. Are your arms and legs lacking in strength?			
16. Do you exercise regularly?			
17. Are you prone to worry?			
18. Have you been diagnosed with high blood pressure?			
19. Do you sweat a lot without exerting yourself?			
20. Do you feel dizzy or light-headed or have visual changes when you stand up too quickly?			
21. Is you menstruation watery, profuse or pinkish in color?			
22. Are you more tired around ovulation or menstruation?			
23. Do you ever spot a few days or more before your period comes?			
24. Have you ever been diagnosed with uterine prolapsed?			
25. Are your menstrual cramps accompanied by a bearing down sensation in your uterus?			
26. Are you sick often?			

	YES	NO	SOMETIMES
27. Do you have many allergies?			
28. Have you been diagnosed with hypothyroid or anemia?			
29. Do you have hemorrhoids or polyps?			
30. Does your tongue look swollen with teeth marks on the side?			
31. Do you have a pale, yellowish complexion?			
D. (Xue Xu)			
1. Do you have dry, flaky skin?			
2. Are you prone to getting chapped lips?			
3. Are your fingernails or toenails brittle?			
4. Are you losing hair on your head? (all over not in patches)			
5. Is your hair brittle or dry?			
6. Is your nighttime vision diminished?			
7. Do you get dizzy or light-headed around your period?			
8. Are your lips, tongue, or inside your lower eyelids pale?			
9. Are your menses late and/or scanty?			
E. (Xue Yu)			
1. Is your menstrual flow ever brown or black?			
2. Do you feel midcycle pain around your overies?			
3. Do you have painful, unmovable lumps in your breasts?			
4. Do you experience periodic numbness in your hands and feet, particularly at night?			
5. Do you have varicose or spider veins?			
6. Do you have red hemangiomas on your skin?			
7. Does your complexion appear dark and sooty?			
8. Do you have chronic hemorrhoids?			
9. Does your menstrual blood contain clots?			
10. Have you been diagnosed with endometriosis or uterine fibroids?			
11. Is your lower abdomen tender to light touch?			
12. Can you feel any abdominal lumps in your lower abdomen?			

	YES	NO	SOMETIMES
13. Do you have piercing or stabbing menstrual cramps?			
14. Does your tongue look dark?			
15. Do you have dark spots on your tongue?			
16. Are the veins beneath your tongue twisty and tortuous?			
17. Have you ever been diagnosed with an y vascular abnormality?			
18. Have you ever been diagnosed with any blood clotting disorder?			
F. (Li Qi Yu)			
1. Are you prone to depression?			
2. Are you prone to anger or rage?			
3. Do you have premenstrual irritability?			
4. Do you feel bloated or irritable around ovulation?			
5. Do you feel your ovulation lasts longer than it should?			
6. Are your breasts sensitive or sore around ovulation?			
7. Do you experience nipple pain or discharge?			
8. Do you have a lot of premenstrual breast pain or distention?			
9. Have you ever been diagnosed with elevated prolactin levels?			
10. Do you experience premenstrual bloating?			
11. Are your pupils usually dilated and large?			
12. Do you have difficulty falling asleep at night?			
13. Do you experience heartburn or wake up with a bitter taste in your mouth?			
14. Are your menses painful?			
15. Do you feel your menstrual cramps in the external genital area?			
16. Is the menstrual blood thick and dark or purplish?			
17. Is your tongue dark or purplish?			

	YES	NO	SOMETIMES
G. (HT Xu)			
1. Do you wake up too early in the morning and have trouble falling back asleep?			
2. Do you have heart palpitations, especially when anxious?			
3. Do you have nightmares?			
4. Do you seem low in spirit and/or lacking in vitality?			
5. Are you prone to agitation or extreme restlessness?			
6. Do you fidget?			
7. Is the tip of your tongue red?			
8. Is there a crack in the center of your tongue that extends to the tip?			
9. Do you sweat excessively, especially on your chest?			
H. (XS Heat)			
1. Is your pulse rapid?			
2. Are your mouth and throat usually dry			
3. Are you thirsty for cold drinks often?			

In the space below please note any other questions or concerns you'd like us to address or be aware of:

Thank you for completing this form.