Please take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. All of the information you provide is strictly confidential. The more information I have to work with, the better I can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to fill out this form. **Depending of where you are in your journey to conception some of the questions on this form may not apply to you. Just answer those that are relevant. Thank you!**

Who is your Reproductive Endocrinologist (if applicable)? _____
How long have you been attempting to get Pregnant? _____
Are you sexually active? _____ STDs? _____
What birth control do you currently use? _____ How long have you used it? _____

Menstrual History:

Date of last menstrual period: _____

At what age did you begin your menstruation? □ < 11 □ 11 (Yes/ No) □12-14 □15 □ >15

Is your menstrual cycle regular? (i.e.: 28 days long?) (Yes/ No)

Where are your cramps? (Please check all that apply.) □ None □ Pelvic □ Low Back □ Recto-Vaginal (spotting) □ Thigh/ Leg

Do you have irregular bleeding outside of your menstruation? (Yes / No)

What are the symptoms you experience pre-menstrually? (Please check all that apply.)

□ Anxiety □ Mood Swings
□ Nervousness □ Fluid Retention
□ Headaches □ Food Cravings
□ Tender Breasts □ Difficulty Sleeping

Have your periods changed since they started?
yes no When?_____
Why?_____
_____

What color is your menstrual blood

(check all that apply) □ Pale pink/red □Red
□ Bright Red □ Dark red □ Black
□ Dark red/brown □ Dark purple

# of pads/tampons used: ___ day 1 ___ day 2 ___ day 3 ___ day 4 ___ day 5 ___ day 6+

On your heaviest day, which do you use? (please circle) □ Regular □Super □Super+

How often do you change your pad/tampon?

□ Every hour or less □ Every two hours □ Every 4 hours □ I don't really need to change my pad or tampon, but I do for hygiene

Other: _____

Are your periods painful? □ before period □ during period □ after period

Is the pain □ mild □ moderate □ severe

Is the pain located in: □ low abdomen □ thighs □ low back □ other

Is the quality of the pain □ cramping □ stabbing □ aching □ dull □ burning □constant □comes and goes

Do you pass clots? (please circle) yes no

What colour are the clots?

□ Bright Red □ Dark red □ Brownish □ Black □Dark purple □Mucus

How big are the clots on average?

□ Small stringy □ Small and spotty □ The size of a 10c □ The size of 50c □ Larger

Do you experience pain with the passing of your clots? (please circle) yes no n/a

Do you feel better after passing clots? (please circle) yes no n/a

Other symptoms related to your period:

	Occasional	Frequent		Occasional	Frequent
Discharge			Swollen or painful breasts		
Headaches			Mood swings		
Nausea			Increased appetite		
Constipation			Decreased appetite		
Diarrhea			insomnia		
Cravings					

Do you experience any of the following?

	Occasional	Frequent		Occasional	Frequent
Endometriosis			Fibrocystic breasts		
Ovarian cysts			Breast cancer		
Uterine fibroids			Breast lumps		
Abnormal pap smear			Nipple discharge		
Yeast infections			Vaginal discharge/odor		
Urinary tract infections			Herpes		
PID (pelvic inflammatory disease			HPV (human papilloma virus)		
Genital lesions/discharge			Hysterectomy		
Pain/itching of genitalia			Uterine prolapse		

Is there anything else you would like us to know?

OVULATION

On what cycle day do you ovulate? _____

Do you use an ovulation predictor kit to determine ovulation? _____

Do you chart your Basal Body Temperature? yes no

Do you experience any symptoms at ovulation?

□ Breast tenderness □ Sharp pain □ Cramping □ Bowel movement changes □ Irritability/rage □ Vaginal Discharge □ Increased Libido □Pelvic Twinge / Pain

Do you get cervical mucus at ovulation? yes no For how many days?_____

Describe the quality/quantity of your cervical mucus:

□ None, I never notice any even with internal exam □ Scant, I only notice it with internal exam

□ Moderate, I notice some on my underwear and when I urinate

□ Profuse, I notice large amounts in my underwear and when I urinate

□ Creamy, thick □ Like rubber cement □ Egg white stretchy □ Watery □ Other

Do you notice cervical mucus at other times during your cycle? yes no

If yes, when?_____For how many days?_____

What is the quality of that mucus?

_____

FERTILITY & IVF INFORMATION:

Have you had any testing relating to your fertility? □ Female factor □ Male factor □ Unexplained. Other_____

How many total pregnancies? _____
How many pregnancies carried to term?_____
How many pre-term pregnancies? _____
How many terminations? _____
How many miscarriages? _____ How many living children? _____ Ages: _____

Have you had the following procedures or tests? What were the results? _____

- Hysteroscopy? _____
- Cervical Conization? _____
- Dilation /Curettage (D&C)?_____
- Laparoscopy? _____
- Mammography? _____
- Pelvic / Abdominal Ultrasounds? _____
- Any uterine abnormalities? _____

Libido: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Date of your last obgyn exam: _____

Test	Performed (Yes/No)	Date	Result	Ideal	TCM
Hysterosalpingogram (HSG)					
Clomid Challenge					
Endometrial Biopsy					
Follicular Stimulating Hormone (FSH)					
Leutenizing Hormone (LH)					
Estrogen (Estradiol)					
Progesterone					
Prolactin					
ANY OTHER TESTS					
AMH					

Hormone levels:

- Have you taken any medication relating to your fertility? _____
  Number of IVF procedures? _____ Number of IUIs_____

Has a physician diagnosed a difficulty with fertility due to:

□ Stimulated cycle w/out IUI _____	□ ZIFT _____
□ Stimulated IUI_____	□ IVF _____
□ Non-Stimulated IUI_____	□ IVF/ Donor _____
□ GIFT_____	

What are your treatment goals relating to your fertility?
How would you describe the emotions most closely related to your journey towards pregnancy?

How many stimulated cycles have you had?_____

Cycle 1: No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____
FSH _____ Positive pregnancy Test Y/N Date Started _____
Cycle 2: No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____
FSH _____ Positive pregnancy Test Y/N Date Started _____
Cycle 3: No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____
FSH _____ Positive pregnancy Test Y/N Date Started _____

***** For each symptom you currently have, please rate its severity from 1 to 5 (5 being the worst). Leave blank if not applicable.*****

Indicate health concerns or symptoms with:1-5 (5 being the worst). Leave blank if not applicable.

EARTH ELEMENT
SP/ST

- ☐ Indigestion
- ☐ Heaviness anywhere in body
- ☐ Fatigue/worse after eating
- ☐ Hard to get up in morning
- ☐ Muscles feel tired often
- ☐ Easily bruising and bleeding
- ☐ Bad breath
- ☐ Decreased/Increased appetite
- ☐ Crave sweets
- ☐ Hypoglycaemia
- ☐ Difficulty digesting
- ☐ Gas/belching
- ☐ Insulin sensitivity
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Over-thinking
- ☐ Tendency to gain weight
- ☐ Brain foggy
- ☐ Food allergy
- ☐ Excess worry
- ☐ Stomach ache/ulcer
- ☐ Diarrhea
- ☐ Haemorrhoids
- ☐ Constipation
- ☐ Anaemia
- ☐ Sores in mouth
- ☐ Strong appetite
- ☐ Weak Appetite
- ☐ Nausea
- ☐ Abdominal bloating
- ☐ Low body weight

METAL ELEMENT
Lu/LI

- ☐ Bronchitis SOB
- ☐ Asthma/ allergies
- ☐ Shallow breathing
- ☐ Cough/dry/phlegm
- ☐ Sinus congestion
- ☐ Nasal discharge
- ☐ Post-nasal drip
- ☐ Sinus trouble Itchy/red/painful
- ☐ Dry mouth/throat/nose
- ☐ Skin rashes/hives
- ☐ Snoring
- ☐ Grief/sadness
- ☐ Low resistance to colds or flu
- ☐ Sneezing
- ☐ Mild fever comes and goes
- ☐ Smoke cigarettes

WATER ELEMENT
KI/BL

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Lower back ache/neck pain
- ☐ Urinary /bladder problems
- ☐ Decreased bone density
- ☐ Feel cold easily
- ☐ Reduced sex drive
- ☐ Excess sexual drive
- ☐ craving/avoiding salty foods
- ☐ Fear
- ☐ Dark under eyes
- ☐ Emotional instability
- ☐ Sinus congestion
- ☐ Oedema
- ☐ Darkness under eye
- ☐ Emotional Instability
- ☐ Aversion to cold
- ☐ hot flash/night sweating
- ☐ Hair thinning or loss
- ☐ Pre-mature aging
- ☐ Frequent urination
- ☐ Kidney Stones
- ☐ Perspire very easily
- ☐ Weakness of legs/knees
- ☐ Asthmatic cough
- ☐ Rapid weight change
- ☐ Loose teeth
- ☐ Reduced sexual energy
- ☐ Thyroid problems
- ☐ Diabetes

FIRE ELEMENT
HT/SI

- ☐ Excess joy easily startled
- ☐ Restlessness/ agitation
- ☐ Lack of joy in life
- ☐ Dry scalp
- ☐ Insomnia/sleep problems
- ☐ Vivid dreams
- ☐ Sore throat
- ☐ Cysts, tumours
- ☐ Ear infections
- ☐ Sore throat, tonsillitis
- ☐ Lymphatic swelling
- ☐ Hot palms and soles
- ☐ Heart palpitations
- ☐ Chest pain
- ☐ Aversion to heat
- ☐ Bitter taste in mouth
- ☐ Gum problems
- ☐ Nose bleeds
- ☐ Facial redness
- ☐ Itching/burning skin
- ☐ Skin eruptions,
- ☐ Rashes
- ☐ Thirst
- ☐ Dark Urine
- ☐ Night sweats

WOOD ELEMENT
Liv/GB

- ☐ Migraines
- ☐ Ringing in the ears
- ☐ Poor eyesight
- ☐ Eye infections
- ☐ Dry eyes
- ☐ Eczema
- ☐ Shingles
- ☐ Herpes simplex
- ☐ Warts
- ☐ Nervousness
- ☐ Convulsion, spasms, cramping
- ☐ Irritability/ anger
- ☐ Depression/stress
- ☐ Constipation
- ☐ Haemorrhoids
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Vomiting
- ☐ Gallstones
- ☐ Indecisive
- ☐ Fullness below ribs
- ☐ Headaches
- ☐ Soft/brittle nails
- ☐ Poor circulation
- ☐ Emotional eater
- ☐ Clenching of teeth at night
- ☐ Shoulder/neck tension
- ☐ Insomnia 11pm-3am

OTHER

- ☐ Fatigue
- ☐ Sciatica/nerve pain
- ☐ Cold hands/feet
- ☐ Tendonitis
- ☐ Fatigue
- ☐ Arthritis
- ☐ Carpal tunnel
- ☐ Numbness
- ☐ Bursitis/tendonitis

FEMALE

- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot Flashes
- ☐ Irregular cycle
- ☐ Cramps or backaches
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Congested breast
- ☐ Breast Pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Pregnancy
- ☐ Pregnancy complications

Additional Information

_____
_____
_____
_____
_____
_____
_____
_____