Amy Dickinson, L. Ac., MTCM
Anne Devereux, L. Ac., MSOM
Phone: 303-444-0192

WHOLE BODY BALANCE
Boulder's Complete Wellness Center

Fertility History Form

Name: _____ **Date:** _____

Age of first Menses:_____How many days does the pain last?_____How heavy is the bleeding? ___Light____Normal___Heavy
What Color is the blood?
___Light red____red___dark red____purple___brown____black

Are your periods painful? Yes No
Is there clotting? Yes No
Do you have PMS? Yes No
Does your face break out before or during your period? Yes No
Do your breasts become tender premenstrually? Yes No
Do you bleed or spot between periods? Yes No

How many days are there from one period to the next? _____
Date of last menstrual period? _____

How many pregnancies have you had? ____
How many children do you have? ____
How many abortions have you had? ____
How many miscarriages have you had? ____
How many times has a D&C been performed? ____
Have you ever had an abnormal Pap Smear? __
Do you get yeast infections regularly? _____

Have you ever been diagnosed with a chlamydial infection? Yes No
Have you ever had a venereal disease? Yes No
Do you have any sores on your genitalia? Yes No

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Have you ever been diagnosed with:

Uterine Fibroids or polyps?	Yes	No
Endometriosis?	Yes	No
Pelvic adhesions	Yes	No
Any pelvic abnormalities	Yes	No

Have you had any imaging done on your fallopian tubes?_____

_____

_____

Have you taken any medication (other than contraceptives) for any gynecological condition? _____

If so, for how long? _____

_____

Did they effect your cycles, and if so, how?_____

_____

_____

Do you ovulate on your own? _____

On what day of the cycle?_____

Have you had fertility treatments before?_____

If so, what sort? _____

_____

_____

Of treatment have you undergone?_____

_____

When?_____By whom? _____

Have your fallopian tubes been evaluated medically?_____

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Have you had any hormone labs performed? _____
If yes, what were the results?_____

_____

_____

Do you have a single partner with whom you are trying to conceive?_____

Has he had a fertility workup? If so, what were the results? _____

_____

_____

_____

Is he supportive of your desire to conceive? _____

_____

_____

_____

Which of the following applies to your medical history:

IUD DepoProvera Oral Contraceptives

Mother exposed to diethylstilbestrol (DES) while pregnant with you?___yes____no

How is your sexual energy?_____Low_____Normal_____High
Are you more than 20% above or below your ideal body weight? Above Below

Do you have excessive facial hair? yes_____no
Do you have excessively oily skin? yes_____no
Have you experienced excessive loss of head hair? yes_____no
Do you have a stressful occupation? yes_____no
Do you exercise regularly? yes_____no
Are you presently taking steroids? yes_____no

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Have you been exposed to any known environmental toxins or hormones?

Anything else I should know?

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Please circle Yes or No to each of the following.

(don't worry about what it might mean!)

YES	NO	Do you have low back weaknss, soreness, pain, or knee problems?
YES	NO	Do you have ringing in your ears or dizziness?
YES	NO	Is your hair prematurely gray?
YES	NO	Do you have vaginal dryness?
YES	NO	Is your midcycle cervical mucus scanty or missing?
YES	NO	Do you have dark circles around or under your eyes?
YES	NO	Do you have night sweats?
YES	NO	Do you have hot flashes?
YES	NO	Would you consider yourself afraid a lot?
YES	NO	Do you have low back pain premenstrually?
YES	NO	Is your low back sore or weak?
YES	NO	Are your feet cold, especially at night?
YES	NO	Are you typically colder than those around you?
YES	NO	Is your libido low?
YES	NO	Are you often fearful?
YES	NO	Do you wake up at night or early in the morning because you
YES	NO	have to urinate?
YES	NO	Do you urinate frequently, and is your urine diluted/profuse?
YES	NO	Do you have early morning loose, urgent stools?
YES	NO	Do you have profuse vaginal discharge?
YES	NO	Do you feel cold cramps during your period that respond to a
YES	NO	heating pad?
YES	NO	Does your menstrual blood tend to be dull in color?
YES	NO	Are you often fatigued?
YES	NO	Do you have a poor appetite?
YES	NO	Is your energy lower after a meal?
YES	NO	Do you feel bloated after eating?
YES	NO	Do you crave sweets?
YES	NO	Do you have loose stools, abdominal pain, or digestive problems?
YES	NO	Are your hands and feet cold?

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YES	NO	Is your nose cold?
YES	NO	Are you prone to feeling heavy or sluggish?
YES	NO	Do you feel heavy or groggy in the head?
YES	NO	Do you bruise easily?
YES	NO	Do you think you have poor circulation?
YES	NO	Do you have varicose veins?
YES	NO	Are you lacking strength in your arms and legs?
YES	NO	Are you lacking in exercise?
YES	NO	Are you prone to worry?
YES	NO	Have you been diagnosed with low blood pressure?
YES	NO	Do you sweat a lot without exerting yourself?
YES	NO	Do you feel dizzy or lightheaded when you stand up too fast?
YES	NO	Is your menstruation thin, watery, profuse or pinkish?
YES	NO	Do you ever spot a few days before your period comes?
YES	NO	Have you ever been diagnosed with uterine prolapse?
YES	NO	Are your menstrual cramps associated with a 'bearing-down sensation in your uterus?
YES	NO	Are you often sick, or do you have allergies?
YES	NO	Have you ever been diagnosed with hypothyroid or anemia?
YES	NO	Do you have hemorrhoids or polyps?
YES	NO	Are your menses scanty and/or late?
YES	NO	Do you have dry, flaky skin?
YES	NO	Are you prone to getting chapped lips?
YES	NO	Are your fingernails or toenails brittle?
YES	NO	Are you losing hair on your head (not patches, but everywhere)?
YES	NO	Is your hair brittle or dry?
YES	NO	Do you have diminished nighttime vision?
YES	NO	Do you get dizzy or light-headed around your period?
YES	NO	Is your menstrual flow ever brown or black in color?
YES	NO	Do you feel midcycle pain around your ovaries?
YES	NO	Do you have painful, unmovable breast lumps?
YES	NO	Do you experience periodic numbness or your hands and feet (especially at night)?
YES	NO	Do you have varicose or spider veins?

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YES	NO	Do you have red hemangiomas (cherry-red spots) on your skin?
YES	NO	Do you have chronic hemorrhoids?
YES	NO	Does your menstrual blood contain clots?
YES	NO	Have you been diagnosed with endometriosis or uterine fibroids?
YES	NO	Is your lower abdomen tender to palpation?
YES	NO	Can you feel any abnormal lumps in your lower abdomen?
YES	NO	Do you have piercing or stabbing menstrual cramps?
YES	NO	Have you been diagnosed with any vascular abnormality or clotting disorder?
YES	NO	Are you prone to emotional depression?
YES	NO	Are you prone to anger and/or rage?
YES	NO	Do you become irritable premenstrually?
YES	NO	Do you feel bloated or irritable around ovulation?
YES	NO	Does it feel as if your ovulation lasts longer than it should?
YES	NO	Are your breasts sensitive/sore at ovulation?
YES	NO	Do you experience nipple pain or discharge from your nipples?
YES	NO	Do you have premenstrual breast distention or pain?
YES	NO	Have you been diagnosed with elevated prolactin levels?
YES	NO	Do you become bloated premenstrually?
YES	NO	Do you have difficulty falling asleep at night?
YES	NO	Do you experience heartburn or wake up with your mouth tasting bitter?
YES	NO	Are your menses painful?
YES	NO	Do you feel menstrual cramps in the external genital area?
YES	NO	Is your menstrual blood thick and dark or purplish in color?
YES	NO	Do you wake up early in the morning and find it difficult to get back to sleep?
YES	NO	Do you have heart palpitations, especially when you're anxious?
YES	NO	Do you have nightmares?
YES	NO	Do you seem low in spirit or lacking in vitality?
YES	NO	Are you prone to restlessness or agitation?
YES	NO	Do you fidget?
YES	NO	Do you sweat excessively, especially on your chest?
YES	NO	Are your mouth and throat usually dry?
YES	NO	Are you thirsty for cold drinks most of the time?
YES	NO	Is your pulse rate rapid (over 80 beats per minute)?
YES	NO	Do you often feel warmer than those around you?

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YES	NO	Do you wake up sweating or have hot flashes?
YES	NO	Do you break out with red acne (especially premenstrually)?
YES	NO	Do you have a short menstrual cycle?
YES	NO	Do you have vaginal irritation or rashes?
YES	NO	Do you feel tired and sluggish after a meal?
YES	NO	Do you have fibrocystic breasts?
YES	NO	Do you have cystic or pustular acne?
YES	NO	Do you have urgent, bright, or foul-smelling stools?
YES	NO	Does your menstrual blood contain stringy tissue or mucus?
YES	NO	Are you prone to yeast infections and vaginal itching?
YES	NO	Do your joints ache, especially with movement?
YES	NO	Are you overweight?
YES	NO	Do you have foul-smelling, yellow or greenish vaginal discharge?
YES	NO	Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?
YES	NO	Does your lower abdomen feel cooler to the touch than the rest of your trunk?