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Women's Health and Fertility Intake Form

Hawthorne Wellness Center

3942 SE Hawthorne Blvd. • Portland, OR 97214 • (503) 235-5484

Name: ______________________________________ Date of Birth: ____________ Date: ___________

Gynecological/Reproductive History

Attempting Pregnancy currently? ___________ If so, for how long? ____

Currently Pregnant? If so, how far along? ____________ Currently breastfeeding? If so, how long?_____________________

Difficult Scanty or Painful Lactation: ____

Post-Partum Difficulties: ____

Describe: ____

Premature Deliveries: ______________________________ Difficult Deliveries: ______________________________________

Describe: ____

Difficulties in Pregnancy? Describe: ____

____

Age of first Menses: _________ What was it like for you? ____

Date of last Menses: _________ Recent Menstrual Changes? If so, what ? ____

How many days do you normally Bleed? ____________ How many days between Periods? ____________________________

How Heavy is the Bleeding? Heavy Average Light How many Pads/Tampons per day? ________________________

What Color is the Blood? Pale Red Pink Red Dark Red Purple Brown Black

Is the Blood: Watery Clotted Mucousy Thick Stringy Have an Odor

Painful Periods? If so, how many days does pain last? ____________ What makes the pain better? _______________________

Heaviness or Pressure in Pelvis with Periods? Yes No

Have you ever gone more than 2 months without getting your Period? When? ____

PMS: What symptoms? ____ When do they start? ___________________________

Bleeding/Spotting between Periods? If yes, when in cycle? ____

Do you Ovulate Regularly? ________ If so, on what day of your cycle?___________ Is Ovulation Painful?________________

Do you Observe Cervical Mucus Changes with Ovulation? ___________ Bleeding with Ovulation? ______________________

Do any of your symptoms seem to change or worsen around your Period? How? _____________________________________

Menopausal Symptoms:

Describe____

Sleep

How long do you normally sleep? __________ hours per night

I have difficulties with (check all that apply): ______ Falling asleep _______Staying asleep ______Dream-disturbed sleep

______ Waking up at about ________ am/pm and not being able to fall back asleep

Emotional Health

Have you ever been treated for a psychological concern? Yes No

Have you experienced sexual or physical abuse? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

Please rate your overall stress level: Low Medium High

Are you currently working with a counselor? If so, who? ____________________

If possible, please describe the most challenging emotion you experience: ____________________

When do you most often feel this emotion? ____________________

What experiences or activities bring you the most joy and nourishment? ____________________

____

Do you have a spiritual practice? ____________________

What goals do you have for your acupuncture or naturopathic treatments? ____________________

____

Comments- please describe anything else you would like to discuss. ____________________

Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to complete this form.

Fertility Clinic ____________________

Physician ____________________

Western Medical Diagnosis (if any)____________________

____

____

Western Diagnostic Tests & Hormone Panels (include dates & results)

- Hysterosalpingogram (HSG) ____________________
- Endometrial Biopsy ____________________
- Clomid Challenge test ____________________
- Follicle Stimulating Hormone (FSH) ____________________
- Luteinizing Hormone (LH) ____________________
- Estradiol (estrogen) ____________________
- Progesterone ____________________
- Prolactin ____________________
- Doppler ultrasound (blood flow) ____________________
- Hysteroscopy/Saline Infused Sonogram____________________
- Any additional tests ____________________

  ____

GYN related surgeries (dates & outcome):

A.R.T. History:

Intrauterine Insemination (IUI) Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

In Vitro Fertilization (IVF) Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

Male Factor (please include dates, results and any applicable treatment)

- ❖ Sperm Count (#/cc) ______________________________
- ❖ Sperm Motility (% moving) ______________________________
- ❖ Sperm Morphology ______________________________
- ❖ Sperm Rise ("swim up test") ______________________________
- ❖ Anti-sperm Antibodies ______________________________
- ❖ Varicocele (including surgery) ______________________________
- ❖ Sperm penetration assay (SPA) ______________________________
- ❖ Other male factor concerns ______________________________

Other Past Treatments Please indicate any other forms of past treatment, both conventional and alternative.

Do you have any other comments, concerns, or issues that you would like to discuss?