City Pulse Acupuncture

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www.CityPulseAcupuncture.com

Please note that all information is strictly confidential. Please complete as thoroughly and accurately as possible.

First Name:	Middle Initial:	Last Name:	Nickname:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email address:		Email appt reminders? Yes No	
Marital status: Single Married Partner Divorced Widowed			
Date of birth:	Age:	SSN:	
Gender:	Height:	Weight:	

Reproductive Endocrinologist:	Start Date:
OB/GYN:	Start Date:
Fertility Center:	Start Date:
Other Reproductive Endocrinologist:	Start Date:
Western Medical Diagnosis:	Date of Diagnosis:

Gynecological History		
Age at first menses:	Date of last menses: / /	Today is cycle day?
Average number of days of flow?	Are your periods regular? Yes No	Length of cycle: days (0=amenorrhea)
Does your period cause cramping or pain? Yes No		When? Before During After period
How long have you been trying to conceive?		
Natural ovulation? Yes No	Which day of your cycle _____ to _____?	
Clomid challenge test? Yes No	Date:	FSH: at cycle day 3:_____ at cycle day 10 _____ at date: _____
Date of last pap smear: / /	Ever had an abnormal pap smear? Yes No	When/Why?
Use of Oral Birth Control Pills? Yes No	For how long?	
Recurrent yeast infections?	How often?	
Current treatment plan: (Natural, IUI, IVF, Additional Testing)?		

Fertility Tracking (Yes/No)						
Calendar Tracking	**Basal Body Temperature**	**Cervical Mucous Tracking**	**Ovulation Predictor Kits**	**Saliva Ferning Tests**	**Fertility Monitor**	**Other**

Lab Results and Dates						
Estradiol (Day 3)	FSH (Day 3)	LH	Progesterone	AMH	Prolactin	DHEA

Total Testosterone	Free Testosterone	Androstenedione	TSH	Free T3	T3	Free T4	T4

Test Results and Dates				
Antral Follicle Count (Ultrasound Evaluation)	Hysterosalpingogram (HSG)	Hysteroscopy	Laparoscopy	Endometrial Biopsy

Diagnostics and Dates							
Abnormal FSH or LH Secretion	PCOS	Luteal Phase Defect	Premature Ovarian Failure	Tubal Infertility	Endometriosis	Cervical Narrowing or Blockage	Fibroids or Polyps

Female Health						
Syphilis	HPV	Chlamydia	Gonorrhea	PID	Herpes (HSV)	Other STIs

Obstetrical History							
Have you ever been pregnant? Yes No If yes, please complete the following:							
Month/Year Pregnancy Ended	Pregnancy Outcome*	With Current Partner? (Yes/No)	Infertility Therapy (if so, type)	How long to conceive?	Sex (M/F) and weight of baby (if delivered)	If miscarriage was a D & C done (Yes/No)?	Any complications (Yes/No)?

*V = Vaginal Delivery, CS = C-Section, M = Miscarriage, TOP = Termination of Pregnancy, EP = Ectopic or Tubal Pregnancy

Procedures and Dates							
Date (s)	**Procedures**	**How Many Times?**	**# of Mature Eggs/Follicles**	**# of Embryos (Transferred/ Frozen)**	**Pregnancy (Yes/No)**	**If miscarriage, indicate week, and if D&C**	**Other info**
	Clomophene (Clomid) stimulation with intercourse						
	Clomophene (Clomid) stimulation with insemination						
	Injectable FSH stimulation with intercourse						
	Injectable FSH stimulation with insemination						
	Insemination without drug stimulation						
	In vitro fertilization						
	In vitro fertilization with ICSI						
	In vitro fertilization with PGD						
	In vitro fertilization with donor eggs						
	Cancelled in vitro fertilization attempt(s)						
	Other procedures						

Male Partner/Donor Health Information:

Has your partner/donor previously conceived with another woman? **Yes** **No**
Has your partner/donor ever consulted a urologist or male infertility specialist? **Yes** **No**
If yes, Year: _____ Reason: _____
Findings and Recommendations: _____
Name of doctor/fertility specialist: _____

Has your partner/donor have or ever had any difficulties with:
Erection: If yes, please explain: _____
Ejaculation: If yes, please explain: _____
Have his genitals ever been exposed to excessive heat? **Yes** **No**
Has he had any serious injuries to his genitals? **Yes** **No**
Has he ever had any infections of his penis, testicles or prostate gland? **Yes** **No**

Male Health						
Syphilis	**HPV**	**Chlamydia**	**Gonorrhea**	**PID**	**Herpes (HSV)**	**Other STIs**

Has your partner/donor ever had a semen analysis? **Yes** **No**
If yes, please complete the following:

Results of Semen Analysis					
Date	**Location of Semen Analysis/Name of Lab**	**Count (million/mL)**	**Motility**	**Morphology**	**Volume**

Male Surgical History					
Date	**Varicocele Repair**	**Vasectomy**	**Vasectomy Reversal**	**Ejaculatory Duct Resection**	**Other**