Restorative Acupuncture

Gilian Lata, LAc, Dipl OM

Date: _____ Referred By: _____

Name: _____ DOB/Age: _____

Significant Other: _____ DOB/Age: _____

Primary GYN: _____ Number of years together: _____

Phone number & Address: _____

MENSTRUAL/HORMONAL

1. Age at which menses began: ____ 2. Did you have any problems? ( ) yes ( ) no If yes, please explain: _____

_____

3. Date of last two menstrual periods: __/__/__ and __/__/__ 4. Do your periods come at regular intervals? ( ) yes ( ) no

5. How many days do you normally bleed? _____ 6. How many days from onset to onset? _____

7. How heavy is the bleeding? ( ) Light ( ) Medium ( ) Heavy 8. Do you bleed or spot between periods? ( ) yes ( ) no

9. What color is the blood? ( ) Light Red ( ) Red ( ) Dark Red ( ) Purple ( ) Brown ( ) Black

10. Is there clotting? ( ) yes ( ) no 11. Do you have premenstrual tension? ( ) yes ( ) no

( ) Irritability ( ) Low Back Pain ( ) Constipation ( ) Diarrhea ( ) Cramping ( ) Water Retention ( ) Cravings

12. Do you get acne premenstrually? ( ) yes ( ) no 13. Do your breasts become tender premenstrually? ( ) yes ( ) no

14. If you have any of these symptoms, when in the cycle do they occur and for how long? _____

15. Are your periods painful? ( ) yes ( ) no If so, when and how long does it last? _____

16. Have you been charting your cycle (temperature, cervical mucous, opening)? ( ) yes ( ) no

17. Do you ovulate on your own? ( ) yes ( ) no 18. If yes, on what day of your cycle? _____

19. Have you had any of the following?

( ) Hot Flashes
( ) Breast discharge
( ) Visual Disturbance
( ) Chronic Headache
( ) Increased facial/body hair
( ) Vomiting
( ) Weight Increase > 10 pds
( ) Weight Decrease < 10 pds
( ) Extraordinary Stress
( ) Excessive loss of head hair

20. If yes, please explain: _____

PREGNANCY HISTORY

1. Pregnancies __ 2. Term Births __ 3. Premature Births __ (what week) 4. Miscarriages __ (# of weeks) 5. Elective Abortion __

Date	Miscarriage	Elective Abortion	D&C	Ectopic Pregnancy	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complications	Is current partner the father?

CONTRACEPTION USE

Type	From When to When	Reason discontinued

MEDICATIONS (Prescription and Over the Counter for gynecological condition other than contraceptives)

Date	Dose & Frequency	From When to When	Reason

GYNECOLOGICAL

1. Have you ever had an abnormal pap smear? ( ) yes ( ) no 2. Date of last pap smear? _____

3. Do you get yeast infections regularly? ( ) yes ( ) no 4. Have you had an STD (sexually transmitted disease)? ( ) yes ( ) no

If yes, what was it and how was it resolved? _____

5. Do you have chronic vaginal discharge? ( ) yes ( ) no 6. Do you have any sores on your genitalia ( ) yes ( ) no

7. Have you ever had a cervical biopsy, operation, cauterization, or freezing (cryo)? ( ) yes ( ) no If so, please explain:

_____

8. Have you ever had pelvic inflammatory disease (PIV)? ( ) yes ( ) no 9. If yes, were you treated for it? ( ) yes ( ) no

10. How? _____

11. Have you ever been diagnosed with uterine fibroids or polyps? ( ) yes ( ) no

12. Have you ever been diagnosed with endometriosis? ( ) yes ( ) no

13. Have you ever been diagnosed with pelvic adhesions? ( ) yes ( ) no

14. Have you ever been diagnosed with any pelvic abnormalities? ( ) yes ( ) no

15. Have you ever been diagnosed with PCOS (Polycystic Ovarian Syndrome)? ( ) yes ( ) no

16. Have you ever been diagnosed with LUFS (Luteinized Unruptured Follicle Syndrome)? ( ) yes ( ) no

17. Other: _____

GENETIC HISTORY Do you, your partner, or anyone in your family have:

( ) Neural tube defects/spina bifida/anencephaly
( ) Thalassemia
( ) Down Syndrome
( ) Cystic Fibrosis
( ) Muscular Dystrophy
( ) Huntington's Chorea
( ) Mental Retardation/Fragile X
( ) Tay-Sachs Disease
( ) Sickle Cell disease or trait
( ) Hemophilia
( ) Hormonal Disorder
( ) Chromosomal Disorder
( ) Genetic/Inherited Disorder
( ) Baby with birth defects
( ) Infertility

FERTILITY HISTORY

1. How long have you been trying to conceive? _____ 2. Are you seeing a reproductive specialist? ( ) yes ( ) no

3. If yes, name, phone number and address? _____

4. What cause of infertility was diagnosed? _____

5. How is your sexual energy? ( ) Low ( ) Normal ( ) High 6. Do you douche regularly? ( ) yes ( ) no

7. Do you use vaginal lubricants? ( ) yes ( ) no 8. Do you have a stressful occupation? ( ) yes ( ) no

9. Are you more or less than 20% over your ideal body weight? ( ) yes ( ) no 10. Do you exercise regularly? ( ) yes ( ) no

11. Were you or your partner exposed to DES as a fetus? ( ) yes ( ) no

12. Have you been exposed to any other toxins? ( ) yes ( ) no

13. Did you mother or any siblings have any problems getting pregnant or have a miscarriage? ( ) yes ( ) no

14. If yes, please explain: _____

15. What drugs have you taken for infertility (please circle the individual drug)?

( ) SERMS (Clomid, Femara, Serophene)
( ) hMG (Repronex, Pergonal, Humegon, Ovidrel, Menogon)
( ) hCG (Pregnyl, Profasi, Novarel)
( ) GnRH agonists (Lupron, Zoladex, Synarel)
( ) GnRH antagonists (Antagon, Cetrotide, Ganirelix)
( ) Bromocriptine (Parlodel) & Cabergoline (Dostinex)
( ) FSH (Follistim, Fertinex, Bravelle, Gonal-F)
( ) Progesterone
( ) Steroids (Prednisone)
( ) Aspirin
( ) Heparin
( ) Oral Contraceptives
( ) Metformin (Glucophage)
( ) Luveris
( ) Other (explain): _____

16. What tests have you had?

( ) Clomid Challenge Test	When__/__/__	Results: _____
( ) Postcoital Test	When__/__/__	Results: _____
( ) Hormonal Assays (FSH, LH, DHEA-S, Testosterone, Pregesterone)	When__/__/__	Results: _____
( ) Endometrial biopsy	When__/__/__	Results: _____
( ) Hysterosalpingogram	When__/__/__	Results: _____
( ) Sono-hysterogram	When__/__/__	Results: _____
( ) Ultrasound	When__/__/__	Results: _____
( ) Laparoscopy, Hysteroscopy	When__/__/__	Results: _____
( ) Viral/Infection Tests	When__/__/__	Results: _____
( ) Thyroid tests	When__/__/__	Results: _____
( ) Antibody screen (IBT)	When__/__/__	Results: _____
( ) Genetic screening	When__/__/__	Results: _____

MALE

( ) Semen culture	When__/__/__	Results: _____
( ) Sperm Penetration Assay	When__/__/__	Results: _____
( ) Sperm Mucous Penetration	When__/__/__	Results: _____
( ) Urinalysis	When__/__/__	Results: _____
( ) Testicular biopsy	When__/__/__	Results: _____
( ) Sperm Antibody Test (IBT)	When__/__/__	Results: _____
( ) Vasography	When__/__/__	Results: _____
( ) Ultrasonography	When__/__/__	Results: _____
( ) Other	When__/__/__	Results: _____

17. What procedures have you had?

( ) Tubal surgery	When__/__/__	Results: _____
( ) IUI (Intrauterine Insemination)	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
( ) IVF (In Vitro Fertilization)	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____

	When__/__/__	Results: _____
( ) GIFT	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
( ) ZIFT	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
( ) Other (explain)	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____
	When__/__/__	Results: _____

If yes, ( ) partner sperm ( ) donor sperm

MALE

( ) Vericocele repair	When__/__/__	Results: _____
( ) Endocrine Therapy	When__/__/__	Results: _____
( ) Other (explain)	When__/__/__	Results: _____

18. Please list any other information that you think it is pertinent: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for errors or omissions I may have made in the completion of this form.

Patient Signature: _____ Date: _____