



Balancing Point Center for Wellness WOMEN'S FERTILITY QUESTIONNAIRE

Name: _____ Date: _____

1. Basic Information

a. Address: _____

b. Date of Birth: _____ Age: _____ Gender: Female Male

c. Home # _____ Cell#: _____ Best # to reach you?: _____

2. Menstrual History

a. At what age did you begin your menses? _____

b. Are your periods painful? No Yes

c. When was your last menstrual cycle? _____

d. Do you have any problems with your cycle?
No Yes

e. Is your cycle normal?
o Length of Cycle: _____ days
o Days of bleeding: _____ days

f. Amount of bleeding:
Heavy Med Light

g. Color of the blood:
Lt Red Red Dark Red
Purple Brown /Black

h. Is there clotting? No Yes

i. Fatigue? Before During After

j. Premenstrual Symptoms (Mark all that Apply)
Migraines Water Retention
Tender Breasts Facial Acne
Irritability Spotting b/t periods
Appetite Changes Low Back Pain

3. Gynecologic History

a. Date of Last Pap Smear : _____
o Was it normal? No Yes

b. Have you ever:
o Had an abnormal pap smear? No Yes
o Had a cervical biopsy? No Yes
o Had a cervical surgery? No Yes
o Had/have a venereal disease? No Yes
o Had/have chronic vaginal discharge? No Yes
o Had/have sores on your genitalia? No Yes

c. Have you ever been diagnosed with:
o Uterine fibroid? No Yes
o Pelvic adhesions? No Yes
o Pelvic inflammatory disease? No Yes
o Pelvic abnormalities? No Yes
o Polycystic ovary disease? No Yes
o Luteinized unruptured follicle syndrome? No Yes

d. Have you ever been diagnosed with (Mark all that apply):
Endometriosis Yeast Infection Lupus Diabetes

4. Family History

a. Do you have family history of (If marked yes, please explain):

Cancer	_____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
Stroke	_____
Mental Illness	_____
Kidney	_____
Bladder Disease	_____
Thyroid Disease	_____
Arthritis	_____
Allergies	_____

5. Fertility History

- a. Have you ever been pregnant? No _____ Yes; If yes, mark all that apply, and write how many timed
 Miscarriage _____ Abortion _____ Live Births _____
- b. How long have you been trying to conceive?
 <6 Months 6-12 Months 12-18 Months 18-24 Months 2-3 Years >3 Years
- c. Have you had fertility treatments? No _____ Yes (If Yes, please mark which, list dates)
 IUI IVF GIFT ZIFT Microimplantation Other: _____
- i. When and Where? _____
- d. What other treatments have you tried?
 Acupuncture Herbs Nutritionist Massage Chinese Medicine
 Other (Explain): _____
- e. Have you taken oral contraception? No _____ Yes (If yes, please mark all that apply)
 Contraceptive Pills Nuvaring IUD Depopreva Diaphragm Other: _____
 When and how long? _____
- f. Do you take any other medications?
 Antihistamines Decongestants Aspirin Advil/Aleve Antibiotics Antidepressants Insulin
 Others: _____
- g. Have you been charting your fertility with basal body temperature? No _____ Yes _____
- h. Have long have you been trying to achieve pregnancy with your current partner? _____
- i. Have you ever tried to conceive with a different partner? No _____ Yes _____
- ii. Has your male partner gotten someone else pregnant? No _____ Yes _____
- iii. Has he had a fertility workup? No _____ Yes _____
- i. Are you seeing a reproductive specialist? No _____ Yes: _____
- j. Have you been diagnosed with infertility? No _____ Yes: _____

6. Physical History (Please mark all that apply):

a. Emotions <input type="checkbox"/> Normal <input type="checkbox"/> Depression <input type="checkbox"/> Sadness <input type="checkbox"/> Panic Attack <input type="checkbox"/> Worries <input type="checkbox"/> Anger <input type="checkbox"/> Anxiety	b. Energy <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Up and Down <input type="checkbox"/> Exhausted <input type="checkbox"/> Hyperactive <input type="checkbox"/> Nervous Energy <input type="checkbox"/> Abundant	c. Sleep Pattern <input type="checkbox"/> Normal <input type="checkbox"/> Insomnia <input type="checkbox"/> Difficult Falling Asleep <input type="checkbox"/> Wake up at night <input type="checkbox"/> Take Naps <input type="checkbox"/> Wake up too early <input type="checkbox"/> Sleep in Daytime	d. Sleep Quality <input type="checkbox"/> Deep <input type="checkbox"/> Light <input type="checkbox"/> Bad <input type="checkbox"/> Many Dreams <input type="checkbox"/> Bad Dreams <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Talking in sleep
e. Temperature <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Feel cold easily <input type="checkbox"/> Feel hot easily <input type="checkbox"/> Alternate hot and cold <input type="checkbox"/> Sensitive to changes <input type="checkbox"/> Cold hands & feet	f. Sweating <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Too easily <input type="checkbox"/> Too much <input type="checkbox"/> Difficult <input type="checkbox"/> Too Little <input type="checkbox"/> Night Sweats	g. Sensitivities/Allergies <input type="checkbox"/> Normal <input type="checkbox"/> Light <input type="checkbox"/> Noise <input type="checkbox"/> Airborne particles <input type="checkbox"/> Food <input type="checkbox"/> Drugs <input type="checkbox"/> Cold/Hot	h. Appetite/Digestion <input type="checkbox"/> Normal <input type="checkbox"/> Rapid Hungering <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Bloating <input type="checkbox"/> Gas
i. Bowel Movement <input type="checkbox"/> Normal <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loose <input type="checkbox"/> Watery <input type="checkbox"/> Hard and Dry	j. Drinking <input type="checkbox"/> Normal <input type="checkbox"/> Thirsty <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Drink a lot <input type="checkbox"/> Not thirsty, drink a lot	k. Urination <input type="checkbox"/> Normal <input type="checkbox"/> Frequent <input type="checkbox"/> Urgent <input type="checkbox"/> Burning/Painful <input type="checkbox"/> Cloudy <input type="checkbox"/> Dark Color	l. Lifestyles <input type="checkbox"/> Normal <input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana <input type="checkbox"/> Drugs <input type="checkbox"/> Occupational Hazards

Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your midcycle fertile cervical mucus scanty or missing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Kidney Yang Xu

	Yes	No	Don't Know
Do you have lower back pain premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early in the morning because you have to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine diluted and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel cramps during your period that respond to a heating pad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Spleen Qi Xu

	Yes	No	Don't Know
Are you often tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse, or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation or menstruation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period comes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Xue Xu

	Yes	No	Don't Know
Are your menses scanty and/or late?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing hair on your head (not in patches, but all over)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Xue Yu

	Yes	No	Don't Know
Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel midcycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience periodic numbness of your hands and feet (especially at night)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have red hemangiomas (cherry-red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and "sooty"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender with pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abnormal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Liver Qi Yu

	Yes	No	Don't Know
Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated or irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it feel as if your ovulation lasts longer than it should?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distention or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark, or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Heart Xu

	Yes	No	Don't Know
Do you wake up early in the morning and have trouble getting back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking vitality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Shi Heat

	Yes	No	Don't Know
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| Do you wake up sweating or have hot flashes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you break out with red acne (especially premenstrually)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a short menstrual cycle? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have vaginal irritation or rashes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Damp

- | | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| Do you feel tired and sluggish after a meal? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have fibrocystic breasts? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have cystic or pus-filled acne? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have urgent, bright, or foul-smelling stool? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your menstrual blood contain stringy tissue or mucus? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you prone to yeast infections and vaginal itching? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your joints ache, especially with movement? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you overweight? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DampHeat

- | | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Do you have foul-smelling, yellow, or greenish vaginal discharge? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you prone to vaginal and/or rectal itching premenstrually? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ACUPUNCTURE INFORMATION & INFORMED CONSENT

Needles Only sterile, disposable needles are used.

What To Expect On Your First Visit

- Allow yourself 1 hour for your first treatment and 30-45 minutes for follow-up visits.
- Always eat before you come for the treatment. You should not have acupuncture when you are hungry.
- Once escorted into a treatment room, the Doctor will begin your evaluation by asking you many questions.
- Generally speaking, the Doctor will not discuss your diagnosis in oriental medical terms.
- Upon conclusion of your first visit, the Doctor will make a treatment recommendation. This may include a certain number of treatments within a certain amount of time. Please take these suggestions seriously as they are based on years of experience as well as your individual circumstances, and are important to your health and well-being.
- Please utilize this time to ask any questions that you may have.

What To Expect AFTER Your First Visit

- After the treatment, the most common feeling is being relaxed but some people feel energized. Take a few minutes to rest and drink some water.
- Note how you feel: both physically, mentally, and emotionally until the next treatment. Please inform your Doctor of any changes at your next visit so your treatment can be modified if necessary.
- On rare occasions one's original symptoms may briefly get worse after the first treatment. A flare-up typically occurs later on the day of your treatment for a few hours and then improvement and relief follow. In the long run, acupuncture does not make symptoms worse.
- After the treatment, please do not exercise vigorously for the rest of the day. A mild walk is fine.
- Please avoid exposure to extreme hot or cold temperature after the treatment.
- If you have any additional questions or concerns after your treatment, please do not hesitate to telephone or email us.

X

Signature

Date