



## Fertility Acupuncture Initial Consultation: The Mitchell Hill Clinic

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Partner's Age: \_\_\_\_\_

No of years together/married: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Home Tel: \_\_\_\_\_

Work Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

GP: \_\_\_\_\_ Consultant: \_\_\_\_\_

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Main reason for the acupuncture consultation	Enhance natural fertility	<input type="radio"/>	Stress	<input type="radio"/>
	Starting IVF	<input type="radio"/>	Recurrent Miscarriage	<input type="radio"/>
	To regulate cycles	<input type="radio"/>	General wellbeing	<input type="radio"/>
	PCOS	<input type="radio"/>	Menopausal symptoms	<input type="radio"/>
	Endometriosis	<input type="radio"/>	To relieve pregnancy symptoms	<input type="radio"/>
	To reduce FSH	<input type="radio"/>	Unexplained infertility	<input type="radio"/>
	Premature menopause	<input type="radio"/>	Other	<input type="radio"/>

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### Fertility History

How long have you been trying for a baby?  
\_\_\_\_\_

Have you ever been pregnant?  
\_\_\_\_\_

Have you ever had a miscarriage?

*Please give details:*  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an ectopic pregnancy?

*Please give details:*  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any children?

*Please give details:*  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently using contraception?  
\_\_\_\_\_



## Menstrual History

How old were you when you first started menstruating?

How often do you get your period and for how many days?

Do you pass any clots during your period?

Do you have any bleeding or spotting mid cycle?

Have you ever had irregular cycles (varying by more than 7 days)?

Are your periods light, average or heavy?

Do you have painful periods?

Do you know at what age your mother experienced the menopause?

Do you suffer any pre-menstrual symptoms?

*Please give details:*

## Fertility Signs

Are you aware of your fertile time?  Yes  No

If yes, how do you determine this time?

Are you aware of your normal pattern of cervical mucus secretions?

Yes  No

Have you used any ovulation prediction kits (e.g. LH urine test kits)?

Yes  No

Have you used temperature charts?

Yes  No

## Cervical Smears & Sexual Health Screen

What was the date of your last cervical smear?

Have you ever had an abnormal smear?  Yes  No

Have you had a recent sexual health screen?  Yes  No

If "Yes" please give date

Have you ever had a sexually Transmitted Infection?  Yes  No

If "Yes" please give details



## Sexual History

How often do you have sex?

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Have you tried to target intercourse to conceive?  Yes  No

Do you ever experience pain during or after intercourse?  Yes  No

Do you ever experience any bleeding after intercourse?  Yes  No

Do you experience any sexual difficulties, including lack of desire?  Yes  No

Do you use any lubricating gels or creams during intercourse?  Yes  No

Do you think that trying for a baby has affected your sex life?  Yes  No

## Medical History

Do you have any known medical problems?  Yes  No

If "Yes" please give details

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Are you taking any medication at present, if so, what?

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## Sleep

How many hours do you sleep?

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Do you fall asleep o.k.?  Yes  No

Do you wake up during the night, if so, usually at what time?  Yes  No

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## Body Temperature

Are you more sensitive to heat or cold?

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Do you suffer from 'poor circulation' e.g. cold hands or feet?  Yes  No

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## Digestion

Do you suffer from:

Heartburn	<input type="radio"/>	Bad Breath	<input type="radio"/>
Indigestion	<input type="radio"/>	Diarrhoea	<input type="radio"/>
Bloating	<input type="radio"/>	Constipation	<input type="radio"/>
Flatulence	<input type="radio"/>	Irritable Bowel Syndrome	<input type="radio"/>
Stomach Pain	<input type="radio"/>	Other	<input type="radio"/>



## Diet

How do you rate your diet and nutrition?

- (1) Not very healthy
- (2) Healthy and well balanced some of the time
- (3) Healthy and well balanced most of the time
- (4) Healthy and well balanced all of the time

Do you eat three meals a day?  Yes  No

Do you crave sweet foods?  Yes  No

Do you have a drop in energy during the day, if so when?

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Do you snack between meals, if "Yes" please give examples?  Yes  No

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Do you or have you suffered from eating disorder e.g. anorexia, bulimia?

Yes  No

If "Yes" please give details

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## Lifestyle Analysis

How many hours a week do you work?

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Do you exercise, if so what and how often?

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Do you smoke, if so how many per day?

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Do you drink alcohol, if so how many units per week?

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Do you take recreational drugs?  Yes  No

If "Yes" please give details

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Do you drink tea or coffee, if so how much per day?

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How do you rate your present energy levels (1 = very low, 10 = very high)?

1      2      3      4      5      6      7      8      9      10

How do you rate your present stress levels (1 = very low, 10 = very high)?

1      2      3      4      5      6      7      8      9      10



### Additional Information

(e.g. results of any recent tests, or medical/family history)

### Partner

Complete if trying for a baby

How old is your partner?

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Has he had a semen analysis in the past year?

Yes  No

If so what was the result?

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Does your partner smoke?

Yes  No

If "Yes" how many?

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Does your partner drink > 10 units of alcohol a week?

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Does your partner take recreational drugs?

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Does your partner drink excess caffeine (>4 drinks a day)?

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Does your partner exercise?

Yes  No

If "Yes" how much and what kind?

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Any known medical/surgical history?

(e.g. hernia/varicocele repair, operation to testes etc.)

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Do you feel well supported by your partner, family and friends?

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**If you are trying for a baby make sure that you are: Immune to rubella, have had an up-to-date cervical smear and that you are taking folic acid 400 mcgs daily.**