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Fertility Acupuncture Initial Consultation: Positive Acupuncture

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: __________________________________

Main reason for the acupuncture consultation

Enhance natural fertility	O	Stress	O
Starting IVF	O	Recurrent Miscarriage	O
To regulate cycles	O	General wellbeing	O
PCOS	O	Menopausal symptoms	O
Endometriosis	O	To relieve pregnancy symptoms	O
To reduce FSH	O	Unexplained infertility	O
Premature menopause	O	Other	O

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?

____

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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? O Yes O No

If yes, how do you determine this time?

___

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

O Yes O No

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

O Yes O No

Have you used temperature charts? O Yes O No

___

Cervical Smears & Sexual Health Screen

What was the date of your last cervical smear?

___

Have you ever had an abnormal smear? O Yes O No

Have you had a recent sexual health screen? O Yes O No

If "Yes" please give date

___

Have you ever had a sexually Transmitted Infection? O Yes O No

If "Yes" please give details

___

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Sexual History

How often do you have sex?

____

Have you tried to target intercourse to conceive? O Yes O No

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

Do you ever experience any bleeding after intercourse? O Yes O No

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

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

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

Medical History

Do you have any known medical problems? O Yes O No

If "Yes" please give details

____

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

____

____

Sleep

How many hours do you sleep?

____

Do you fall asleep o.k.? O Yes O No

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

____

Body Temperature

Are you more sensitive to heat or cold?

____

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

____

Digestion

Do you suffer from:

Heartburn o

Indigestion o

Bloating o

Flatulence o

Stomach Pain o

Bad Breath o

Diarrhoea o

Constipation o

Irritable Bowel Syndrome o

Other o

Diet

How do you rate your diet and nutrition?

(1) Not very healthy o

(2) Healthy and well balanced some of the time o

(3) Healthy and well balanced most of the time o

(4) Healthy and well balanced all of the time o

Do you eat three meals a day? O Yes O No

Do you crave sweet foods? O Yes O No

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

____

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

____

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

O Yes O No

If "Yes" please give details

____

Lifestyle Analysis

How many hours a week do you work?

____

Do you exercise, if so what and how often?

____

Do you smoke, if so how many per day?

____

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

____

Do you take recreational drugs? O Yes O No

If "Yes" please give details

____

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

____

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

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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?

____

Has he had a semen analysis in the past year? O Yes O No

If so what was the result?

____

Does your partner smoke? O Yes O No

If "Yes" how many?

____

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

____

Does your partner take recreational drugs?

____

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

____

Does your partner exercise? O Yes O No

If "Yes" how much and what kind?
____

Any known medical/surgical history?
(e.g. hernia/varicoele repair, operation to testes etc.)

____

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

____
____
____

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.