GRETA WILLIAMS
Acupuncture Family Care

Reproductive Health History Questionnaire

Welcome to Acupuncture Family Care. In addition to the Health History Questionnaire & Contact Information form pages 1 through 3, please complete the following more extensive Reproductive Health History in place of page 4. All information on this form is **confidential**.

First Name: _____ MI:_____ Last Name:_____ Date: _____

GYNECOLOGICAL/OBSTETRICS Information:

Ob/gyn History:

❑ Fibroids ❑ Endometriosis ❑ Ovarian Cysts

❑ Polycystic Ovaries ❑ Thyroid (hyper or hypo) ❑ Other _____

Menstrual Cycle:

Age of menarche/first period: _____ Date of last period: _____

# of Days between cycles: _____ # of Days of bleeding: _____

Pre-menstrual/menstrual symptoms (check off box & circle any relevant information in parentheses):

❑ irritability/anger ❑ crying/sadness ❑ breast tenderness (nipple or breast)

❑ low back pain ❑ bloating ❑ headaches

(Check off any relevant and circle B = Before D = During E = End) ❑ other _____

❑ menstrual cramps (B, D, E) ❑ heavy menstrual flow ❑ light menstrual flow

❑ spotting (B, D, E) # of Days: _____ ❑ Clots: Size (dime/quarter etc): _____

Menstrual Blood color: ❑ Light ❑ Bright Red ❑ Dark Red ❑ Purple ❑ Brown ❑ Black

Other:

❑ mid-cycle pain ❑ irregular periods ❑ no periods

❑ low sex drive ❑ pain on intercourse ❑ Other _____

Discharge:

❑ cervical discharge ❑ vaginal pain/itching ❑ vaginal dryness

❑ yeast infections

Ovulation:

Do you know when you ovulate? ❑ yes ❑ no How do you know: _____

Pregnancies:

How many pregnancies have you had? _____ Miscarriages: _____ Abortions: _____

Vaginal Births:_____ Cesareans: _____

Medical Care:

Date of last ob/gyn exam: _____ Date of last physical: _____

Date last pap smear: _____ NORMAL ABNORMAL

Last breast exam: _____ NORMAL ABNORMAL

Fertility Treatments:

Have you had any ob/gyn tests or exams for reproductive health: ❑ yes ❑ no

If yes, list with results if possible: _____

_____

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Do you know if your 'tubes' are clear: ❑ yes ❑ no

Western Medical Diagnosis (if any): _____

_____

What method(s) are you using/have you used to conceive (ie intercourse, sperm donor, IVF, IUI, other):

_____

IVF Treatments: #_____ Dates: _____ Results:_____

Side-effects/results (ex. Cramping, spotting): _____

IUI Treatments: #_____ Dates: _____ Results:_____

Side-effects/results (ex. Cramping, spotting): _____

Other tests: _____

_____

(If additional space is needed please use additional sheet of paper or the back of sheet.)

Has your partner been tested? ❑ Yes ❑ No Results: _____

_____

❑ Other comments/concerns: _____

List Surgical procedures:

Procedure/Reason	Date	Results/Reaction:

Birth control use (number of years):

❑ Birth Control Pill Dates: _____ ❑ IUD Dates: _____ ❑ Other _____ Dates: _____

Any significant history with your own birth/delivery? _____

_____

Sexually Transmitted Infections:

❑ HPV – Genital Warts Date: _____ Symptoms/Treatment: _____

❑ Herpes Simplex I or II Date: _____ Symptoms/Treatment: _____

❑ Chylmydia Date: _____ Symptoms/Treatment: _____

❑ Syphilis/Gonorrhea Date: _____ Symptoms/Treatment: _____

❑ Other _____ Date: _____ Symptoms/Treatment: _____