

WOMEN'S REPRODUCTIVE HISTORY

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CONFIDENTIAL

Have you taken medication to help you ovulate? Yes No
When? _____
How long? _____
Have your fallopian tubes been evaluated medically? Yes No
What were the results? _____

Have you had any tubal operations? Yes No
Have you had any hormone laboratory tests performed? Yes No
What were the results? _____

Do you have a single partner with whom you have been trying to
conceive? Yes No
How long have you been married or living together? _____
Has he had a fertility workup? Yes No
What were the results? _____

Is your partner supportive in your wish to conceive? Yes No
How is your sexual energy? low normal high
Do you douche regularly? Yes No
With what? _____

Do you use vaginal lubricants? Yes No
Are you more than 20% over your ideal body weight? Yes No
Are you more than 20% below your ideal body weight? Yes No
Do you have a stressful occupation? Yes No
Do you exercise regularly? Yes No
Do you have excessive facial hair? Yes No
Do you have excessively oily skin? Yes No
Have you experienced excessive loss of head hair? Yes No
Have you noticed discharge from your nipples? Yes No
Was your mother exposed to diethylstilbestrol (DES) when she was
pregnant with you? Yes No
Have you been exposed to any known environmental toxins
or hormones? Yes No

Are you presently taking steroids? Yes No
Have you taken oral contraceptives? Yes No
When? _____
How long? _____

Have you ever had an IUD? Yes No
When _____
How long? _____

Have you ever taken DepoProvera? Yes No
When? _____
How long? _____

How long have you been trying to conceive? _____
Have you had a diagnosis relating to infertility? Yes No
What was it? _____

ADDITIONAL COMMENTS/NOTES:



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