



Patient Registration Forms
CONFIDENTIAL

Name: _____ Date: _____

Age: _____ Date of Birth: ____/____/____ Sex: _____ Male _____ Female _____

Marital Status: _____ Single _____ Married _____ Partnered _____ Divorced _____ Widowed _____

Spouse's/Partner's Name: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _(____) _____ Cell Phone: _(____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Phone: _(____) _____ Relation: _____

Insurance Carrier: _____ Policy #: _____

Name of your Medical
Doctor: _____

How did you hear about our clinic? _____

Who may we thank for referring you? _____



Health History Forms
CONFIDENTIAL

How long have you been trying to conceive? _____

Have you received a western diagnosis regarding your fertility? Yes No

If yes, please describe:

How long has this conditions persisted? _____

What are you planning to do? IVF IUI Other

Estimated date of procedure? _____

What drugs/medications will you be taking in preparation for this procedure, and when do you start?

Have you received fertility treatments in the past? Yes No

If yes, when and where? _____ By whom? _____

What type of treatment? _____

Have your fallopian tubes ever been evaluated medically? Yes No

What were the results? _____

Have you ever had your FSH level checked on Day 3? Yes No

If yes, what was it at? _____

Have you had any tubal operations? Yes No

Have you had any lab tests performed to check your hormone levels? Yes No

What were the results?

Has your partner or spouse had a fertility workup? Yes No

What were the results?

Have you received any irregular lab work for your thyroid? Yes No

Do you have natural killer cells? Yes No

Do you have elevated prolactin? Yes No

Have you done LIT or IVIG? Yes No When? _____

Have you take oral contraceptives? Yes No

When? _____ For how long? _____

Have you ever taken Depo Provera? Yes No

When? _____ For how long? _____

Have you ever had an IUD? Yes No

When? _____ For how long? _____

Are you presently taking steroids? Yes No

What age did your menstrual cycle begin? _____

What day did you start your last menstrual period? ____/____

Is your cycle regular? Yes No

How many days are there from one period to the next? _____

How many days do you bleed? _____

What color is the blood? Bright Red Light Red Dark Red Purple Brown Black

How heavy do you bleed? Light Normal Heavy

Are your periods painful? Yes Moderate No

How many days does the pain last? _____

Is there clotting? Yes No Size _____ Color _____

If applicable, please check the following pre-menstrual symptoms you experience:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dull cramping | <input type="checkbox"/> Bloating | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Sharp cramping | <input type="checkbox"/> Loose stools | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Hunger/cravings | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Low appetite | <input type="checkbox"/> Acne |

Do you bleed or spot between periods? Yes No

Do you ovulate of your own? Yes No

What day of your cycle? _____

Do you get stretchy cervical mucous at ovulation? Yes No Sometimes

Do your breasts get tender at ovulation? Yes No Sometimes

Do you use a BBT graph to chart your cycle? Yes No Sometimes

Have you taken medication to help you ovulate? Yes No

When? _____ For how long? _____

How many pregnancies have you had? _____

How many children do you have? _____

How many miscarriages have you had? _____

How many abortions have you had? _____

How many times have you undergone a D&C? _____

When was your last pap smear? _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No

Do you have any STD's? Yes No

If yes, please list: _____

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How? _____

Do you get yeast infections regularly? Yes No

How do you treat them? _____

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Do you have uterine fibroids or polyps? Yes No

Have you been treated for them? Yes No When? _____

Have you ever been diagnosed with endometriosis? Yes No

Have you ever been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you ever taken medication for gynecological conditions other than oral contraceptives?

Yes No

Please explain:

Is your spouse/partner supportive of your wish to conceive? Yes No

How is your sexual energy? High Normal Low

Do you use vaginal lubricants? Yes No

Do you douche regularly? Yes No

If yes, with what? _____

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% under your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have dark hairs in places they should not be (i.e. face, nipples, etc.)? 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

Male Fertility History

Do you have undescended testes? Yes No

Have you ever been diagnosed with varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you experienced difficulty maintaining an erection? Yes No

Have you experience difficulty ejaculating? Yes No

Have you had exposure to any known environmental toxins or hormones? Yes No

Do you experience penile discharge? Yes No

Do you regularly experience nocturnal emission? Yes No

Have you had a fertility work up? Yes No

If yes, what was your sperm count? Below normal Normal Number: _____

What was the sperm motility? Below normal Normal Number: _____

What was the sperm morphology? Abnormal Normal Number: _____

Any other questions or comments:

Please sign and date:

Patient Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____