Huffman Wellness

ACUPUNCTURE & HERBAL CLINIC

Women's Fertility History

CONFIDENTIAL

Huffman Wellness Acupuncture & Herbal Clinic ■ 4721 W Kensington Ave. ■ Tampa, FL 33629 ■ Phone & Fax: (813) 831-6060
www.huffmanwellness.com

NAME (LAST, FIRST, MIDDLE) | DATE

Age at which menses began: _____

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

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

Is there clotting? ☐ Yes ☐ No

Do you have premenstrual tension? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

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

Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?		
How many children do you have?		
How many abortions have you had?		
How many miscarriages have you had?		
How many times has a D&C been performed?		

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

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

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Do you have any sores on your genitalia? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No
Were you treated for it? ☐ Yes ☐ No

How _____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long

Have your cycles changed since they began? ☐ Yes ☐ No

How? _____

Do you ovulate on your own? ☐ Yes ☐ No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Do you get premenstral low back pain? Yes No

Do your bowel movements become loose at the beginning of your period?

☐ Yes ☐ No

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ASSISTED REPRODUCTIVE TECHNOLOGY CLINIC

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where? _____

By whom? _____

What types? _____

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 of your wish to conceive? ☐ 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 Depo Provera? ☐ 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? _____

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

COMMENTS/NOTES

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Answer yes or no to each of the following questions. Don't worry about what the symptoms mean: just note whether you experience them. If you have more than one-fourth to one-third yes responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent yes answers for more than one diagnostic category. Note the abbreviation(s) for your category or categories, then find pertinent treatment principles marked throughout the rest of the book.

DIAGNOSIS	*Yes*	*No*
KIDNEY YIN DEFICIENCY (**Ki Yi–**)		
Do you have lower back weakness, soreness, or pain, or knee problems?	☐	☐
Do you have ringing in your ears or dizziness?	☐	☐
Is your hair prematurely gray?	☐	☐
Do you have vaginal dryness?	☐	☐
Is your midcycle fertile cervical mucus scanty or missing?	☐	☐
Do you have dark circles around or under your eyes?	☐	☐
Do you have night sweats?	☐	☐
Are you prone to hot flashes?	☐	☐
Would you describe yourself as afraid a lot?	☐	☐
Does your tongue lack coating? Does it appear shiny or peeled?	☐	☐

DIAGNOSIS	*Yes*	*No*
KIDNEY YANG DEFICIENCY (**Ki Yan–**)		
Do you have lower back pain premenstrually?	☐	☐
Is your low back sore or weak?	☐	☐
Are your feet cold, especially at night?	☐	☐
Are you typically colder than those around you?	☐	☐
Is your libido low?	☐	☐
Are you often fearful?	☐	☐
Do you wake up at night or early in the morning because you have to urinate?	☐	☐

	Yes	No
Do you urinate frequently, and is the urine diluted and/or profuse?	☐	☐
Do you have early morning loose, urgent stools?	☐	☐
Do you have profuse vaginal discharge?	☐	☐
Does your menstrual blood tend to be dull in color?	☐	☐
Do you feel cold cramps during your period that respond to a heating pad?	☐	☐
Is your tongue pale, moist, and swollen?	☐	☐

DIAGNOSIS	Yes	No
SPLEEN QI DEFICIENCY (**Sp–**)		
Are you often fatigued?	☐	☐
Do you have poor appetite?	☐	☐
Is your energy lower after a meal?	☐	☐
Do you feel bloated after eating?	☐	☐
Do you crave sweets?	☐	☐
Do you have loose stools, abdominal pain, or digestive problems?	☐	☐
Are your hands and feet cold?	☐	☐
Is your nose cold?	☐	☐
Are you prone to feeling heavy or sluggish?	☐	☐
Are you prone to feeling heaviness or grogginess in the head?	☐	☐
Do you bruise easily?	☐	☐
Do you think you have poor circulation?	☐	☐
Do you have varicose veins?	☐	☐
Are you lacking strength in your arms and legs?	☐	☐
Are you lacking in exercise?	☐	☐
Are you prone to worry?	☐	☐
Have you been diagnosed with low blood pressure?	☐	☐
Do you sweat a lot without exerting yourself?	☐	☐
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	☐	☐
Is your menstruation thin, watery, profuse, or pinkish in color?	☐	☐
Are you more tired around ovulation or menstruation?	☐	☐
Do you ever spot a few days or more before your period comes?	☐	☐
Have you ever been diagnosed with uterine prolapse?	☐	☐
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	☐	☐
Are you often sick, or do you have allergies?	☐	☐

	Yes	No
Do you have dark spots in your eyes?	☐	☐
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	☐	☐

DIAGNOSIS	Yes	No
LIVER QI STAGNATION (**Lv Qi X**)		
Are you prone to emotional depression?	☐	☐
Are you prone to anger and/or rage?	☐	☐
Do you become irritable premenstrually?	☐	☐
Do you feel bloated or irritable around ovulation?	☐	☐
Does it feel as if your ovulation lasts longer than it should?	☐	☐
Are your breasts sensitive/sore at ovulation?	☐	☐
Do you experience nipple pain or discharge from your nipples?	☐	☐
Do you have a lot of premenstrual breast distention or pain?	☐	☐
Have you been diagnosed with elevated prolactin levels?	☐	☐
Do you become bloated premenstrually?	☐	☐
Are your pupils usually dilated and large?	☐	☐
Do you have difficulty falling asleep at night?	☐	☐
Do you experience heartburn or wake up with a bitter taste in your mouth?	☐	☐
Are your menses painful?	☐	☐
Do you feel your menstrual cramps in the external genital area?	☐	☐
Is the menstrual blood thick and dark, or purplish in color?	☐	☐
Is your tongue dark or purplish in color?	☐	☐

DIAGNOSIS	Yes	No
HEART DEFICIENCY (**Ht–**) *(often associated with heat)*		
Do you wake up early in the morning and have trouble getting back to sleep?	☐	☐
Do you have heart palpitations, especially when anxious?	☐	☐
Do you have nightmares?	☐	☐
Do you seem low in spirit or lacking in vitality?	☐	☐
Are you prone to agitation or extreme restlessness?	☐	☐
Do you fidget?	☐	☐
Is the tip of your tongue red?	☐	☐
Is there a crack in the center of your tongue that extends to the tip?	☐	☐
Do you sweat excessively, especially on your chest?	☐	☐

DIAGNOSIS	*Yes*	*No*
EXCESS HEAT (**^H**)		
Is your pulse rate rapid?	☐	☐
Are your mouth and throat usually dry?	☐	☐
Are you thirsty for cold drinks most of the time?	☐	☐
Do you often feel warmer than those around you?	☐	☐
Do you wake up sweating or have hot flashes?	☐	☐
Do you break out with red acne (especially premenstrually)?	☐	☐
Do you have a short menstrual cycle?	☐	☐
Do you have vaginal irritation or rashes?	☐	☐

DIAGNOSIS	*Yes*	*No*
DAMPNESS (**D**)		
Do you feel tired and sluggish after a meal?	☐	☐
Do you have fibrocystic breasts?	☐	☐
Do you have cystic or pustular acne?	☐	☐
Do you have urgent, bright, or foul-smelling stools?	☐	☐
Does your menstrual blood contain stringy tissue or mucus?	☐	☐
Are you prone to yeast infections and vaginal itching?	☐	☐
Do your joints ache, especially with movement?	☐	☐
Are you overweight?	☐	☐
Do you have a wet, slimy tongue?	☐	☐

DIAGNOSIS	*Yes*	*No*
DAMP HEAT (**DH**)		
Do you have signs of heat and/or dampness as indicated above?	☐	☐
Do you have foul-smelling, yellow, or greenish vaginal discharge?	☐	☐
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	☐	☐

DIAGNOSIS	*Yes*	*No*
COLD UTERUS (**CW**)		
Do you fit the Kidney Yang deficiency (Ki Yan–) category?	☐	☐
Do you fall into the Blood stasis pattern?	☐	☐
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	☐	☐

	Yes	No
Have you been diagnosed with hypothyroid or anemia?	☐	☐
Do you have hemorrhoids or polyps?	☐	☐
Does your tongue look swollen, with teeth marks on the sides?	☐	☐
Do you have a pale, yellowish complexion?	☐	☐

DIAGNOSIS	Yes	No
BLOOD DEFICIENCY (**Bl–**) *(not necessarily equated with anemia)*		
Are your menses scanty and/or late?	☐	☐
Do you have dry, flaky skin?	☐	☐
Are you prone to getting chapped lips?	☐	☐
Are your fingernails or toenails brittle?	☐	☐
Are you losing hair on your head (not in patches, but all over)?	☐	☐
Is your hair brittle or dry?	☐	☐
Do you have diminished nighttime vision?	☐	☐
Do you get dizzy or light-headed around your period?	☐	☐
Are your lips, the inner side of your lower eyelids, or tongue pale in color?	☐	☐

DIAGNOSIS	Yes	No
BLOOD STASIS (**Bl X**) *(often associated with blood deficiency symptoms; see Bl–)*		
Is your menstrual flow ever brown or black in color?	☐	☐
Do you feel midcycle pain around your ovaries?	☐	☐
Do you have painful, unmovable breast lumps?	☐	☐
Do you experience periodic numbness of your hands and feet (especially at night)?	☐	☐
Do you have varicose or spider veins?	☐	☐
Do you have red hemangiomas (cherry-red spots) on your skin?	☐	☐
Does your complexion appear dark and "sooty"?	☐	☐
Do you have chronic hemorrhoids?	☐	☐
Does your menstrual blood contain clots?	☐	☐
Have you been diagnosed with endometriosis or uterine fibroids?	☐	☐
Is your lower abdomen tender to palpation (resisting touch)?	☐	☐
Can you feel any abnormal lumps in your lower abdomen?	☐	☐
Do you have piercing or stabbing menstrual cramps?	☐	☐
Does your tongue look dark?	☐	☐
Do you have dark spots on your tongue?	☐	☐
Are the veins beneath your tongue twisty and tortuous?	☐	☐