Tao of Women
Acupuncture Clinic
Annie Vedeler, L.Ac, Dipl. OM
www.taoofwomen.com
480 359 7389

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?_____

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 one period to the next?_____

Date of last menstrual period_____

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?_____

Do you have chronic vaginal discharge? □ yes □ no

Do you have any sores on your genitalia? □ yes □ no

Have you had fertility treatments? □ yes □ no

If yes, when and where?_____

By whom?_____

What types?_____

Have you ever had pelvic inflammatory disease? □ yes □ no

Were you treated for it? □ yes □ no How?_____

_____

Date of last pap smear_____

Ever been diagnosed with fibroids or polyps? □ yes □ no

Ever been diagnosed with endometriosis? □ yes □ no

Ever been diagnosed with pelvic adhesions? □ yes □ no

Ever been diagnosed with any pelvic abnormalities? □ yes □ no

Ever 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 premenstrual low back pain? □ yes □ no

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

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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 lab tests performed? □ yes □ no

What were the results?_____

_____

Do you have a single partner

with whom you are 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 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?_____

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 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 any steroids?

Comments/Notes:_____

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Fertility and Gynecology Patient History

Name _____ Date _____

Address_____ City _____ State _____

Zip_____ Home phone _____ Work phone _____ Cell _____

Email _____Preferred method of communication: □ email □ call □ text

Have you had acupuncture before? ☐Yes ☐ No

Height _____ Weight _____ Age ___ Sex: ☐ Male ☐ Female Other_____ Date of birth _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Number of children: _____ Ages of children: _____ Number who live with you: _____

Primary Care Doctor: _____ Last seen: _____

OBGYN:_____Last seen:_____

Reproductive Endocrinologist:_____Last seen:_____

Fertility Clinic:_____Last seen:_____

Midwife:_____Last seen:_____

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Emotions / Relationships

Number of biological Brothers: _____ Sisters: _____ Were you adopted? ☐ Yes ☐ No

Your place in the birth sequence #: _____

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety / Worry ☐ Anger ☐ Grief

☐ Fear / Dread ☐ Depression ☐ Melancholy ☐ Happiness ☐ Contentment ☐ Joy

☐ Numbness / Apathy ☐ Other:_____

Do you enjoy your work? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? _____

Do you love where you live? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? _____

Do you feel you have a higher purpose for your life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Do you feel safe in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Do you feel nurtured in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you happy with your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you satisfied with your sex life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life?

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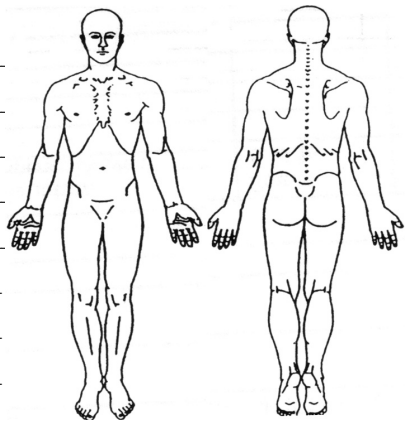
Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements, vitamins and herbs you are currently taking:

Supplement	Reason for taking	Dosage	Frequency

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:
Use the diagram if desired.



The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Annie Vedeler, L.Ac 24 hours prior to any cancellations and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

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