Dr. Kristen Lum ND, LAc

Rivergate Natural Healthcare & Acupuncture

3750 Main Ave. Unit #1 • Durango, CO. 81301
970.382.9100 • drklum@rivergatenaturalhealthcare.com

FERTILITY HEALTH HISTORY

Name *(Last, First, M.I.):*		**Today's Date**	
SSN:			

Menstrual History and Symptoms						
Age of First Menses:		Are your cycles regular?	☐Y / ☐N / ☐P	**Date of Last Menstrual Period**		
Length of cycle from one cycle to the next (days)?				How many days of bleeding during cycle?		
How heavy is your menstrual bleeding?		☐ Light		☐ Normal		☐ Heavy
What color is the blood?	☐ Light Red	☐ Red	☐ Dark Red	☐ Purple	☐ Brown	☐ Black
Is there clotting with menses?		☐Y / ☐N / ☐P		Do you spot or bleed between menses?		☐Y / ☐N
Cramping with menses?	☐Y / ☐N / ☐P	If yes, are they:		☐ Mild	☐ Moderate	☐ Severe
Have you ever missed school or work due to menstrual pain?		☐Y / ☐N / ☐P		Treatment(s) for cramping:		
Premenstrual Symptoms						
Acne?	☐Y / ☐N / ☐P	Breast Tenderness?	☐Y / ☐N / ☐P	Cramping before menses?	☐Y / ☐N / ☐P	
Night sweats	☐Y / ☐N / ☐P	Emotional before menses?	☐Y / ☐N / ☐P	If yes, describe emotional state:		
Ovulation Symptoms						
How do you currently track your ovulation date?				Typical day of menstrual cycle that you ovulate?		
Do you ovulate naturally?		☐Y / ☐N / ☐P		Do you have cervical mucus discharge at ovulation?		☐Y / ☐N / ☐P
Medications & Contraception						
Type of Oral Birth Control Currently Used:		Dose:			Length of Use:	
Type of Birth Control(s) used in Past:	☐ Oral Birth Control	☐ IUD		☐ Depo Provera		☐ Condoms
☐ Diaphragm	☐ Foams / Jellies	☐ Withdrawal Method		☐ Rhythm Method		☐ Tubal Ligation
When did you last use contraception?			Contraceptive Complications:			
Please list all other medication for gynecological conditions (not fertility related):						

Reproductive Health History					
Date of last PAP exam:		Abnormal PAP exam?	☐Y / ☐N / ☐P	If yes, when?	
Number of Pregnancies:			Any complications with pregnancy?		
Number of Live Births:		Number of Abortions:		Number of Miscarriages:	
Have you ever had any of the following (check all that apply):					
☐ Gonorrhea		☐ Venereal Warts		☐ Syphilis	
☐ Chlamydia		☐ Genital Herpes		☐ Pelvic Inflammatory Disease (PID)	
If yes, please explain the year and diagnosis and the treatment:					
Have you ever been diagnosed with any of the following (check all that apply):					
☐ Pelvic Adhesions	☐ Fibroids		☐ Pelvic Abnormalities	☐ Polyps	
☐ Ovarian Cysts	☐ Endometriosis		☐ Yeast Infections	☐ Chronic Discharge	
If yes, please explain the year and diagnosis and the treatment:					
Date of last Mammogram:		**Have you ever had an abnormal Mammogram?**	☐Y / ☐N	**Year:**	
If you have had an abnormal Mammogram, what was done about it?					
Breast lumps or pain?	☐Y / ☐N / ☐P		Nipple discharge	☐Y / ☐N / ☐P	

Pregnancy Health History							
	When? (year)	**How long to conceive? (months)**	**Fertility therapy used?**	**Is current partner the father?**	**Duration of pregnancy? (months)**	**Outcome***	**Complications**
1st Pregnancy			☐Y / ☐N	☐Y / ☐N			
2nd Pregnancy			☐Y / ☐N	☐Y / ☐N			
3rd Pregnancy			☐Y / ☐N	☐Y / ☐N			
4th Pregnancy			☐Y / ☐N	☐Y / ☐N			
5th Pregnancy			☐Y / ☐N	☐Y / ☐N			

***Outcomes:** Vaginal Delivery = VD, Cesarean section = CS, Abortion = AB, Miscarriage = MS, Ectopic = EP

Fertility Health History	
Have you had fertility treatments?	☐Y / ☐N
If yes, where and when?	
Overseeing Physician	
How long have you and your present partner been trying to conceive?	

Have you ever been infertile with a past partner?	☐Y / ☐N	**If so, how long?**	

Have you ever had any of the following tests performed on you? Check all that apply and the results.		
Procedure	**Date**	**Results**
☐ **Basal Body Temperature**		
☐ **Urinary LH (Ovulation) Predictor Kits**		
☐ **Postcoital Test**		
☐ **Hormone Tests**		
☐ **Endometrial Biopsy**		
☐ **Hysterosalpingogram (HSG)**		
☐ **Sonohysterogram**		
☐ **Ultrasound**		
☐ **Antisperm Antibodies**		
☐ **Laparoscopy**		
☐ **Hysteroscopy**		
☐ **Gonorrhea / Chlamydia Culture**		
☐ **Rubella (German Measles)**		
☐ **Hepatitis B or C**		
☐ **HIV**		
☐ **RPR (Syphilis)**		
☐ **Blood Type and Rh**		
☐ **Antibody Screen**		

What types of fertility therapy have you received in the past?

Drug / Treatment	**Dose**	**How long or how many cycles?**	**When?**
Clomiphene citrate (Clomid, Seraphene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metr Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Donor Insemination			

In Vitro Fertilization = ICSI			
Family Health History			
Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you?			☐Y / ☐N
Does any family member have significant health problems or inherited diseases?			☐Y / ☐N
If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease?			☐Y / ☐N
Check all that apply:			
☐ Birth Defects	☐ Down Syndrome	☐ Muscular Dystrophy	☐ Brain / Spinal Defects
☐ Fragile X Syndrome	☐ Sickle Cell Disease	☐ Cancer	☐ Heart Disease
☐ Tay-Sachs Disease	☐ Cystic Fibrosis	☐ Hemophilia	☐ Thalassemia
☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Disease	Who?
Are you from any of these ethnic backgrounds?			
☐ Italian	☐ Jewish	☐ Caucasian	☐ African American
☐ Greek	☐ French Canadian	☐ Filipino	☐ African
☐ Middle Eastern	☐ Cajun	☐ Southeast Asian	☐ Southern Chinese
☐ Spanish	☐ Hispanic	☐ Asian Indian	☐ Taiwanese

Thank you for your time and effort.

We look forward to providing you with the best possible health care.

Patient's or Authorized Person's Signature:

Patient Name (please print):	Patient Signature	Date
RESPONSIBLE PARTY: fill out if you are not the patient but are responsible for the bill.		
Responsible Party	**Relationship to Patient**	