Aquino Acupuncture
& HOLISTIC HEALTH

FERTILITY INTAKE

Patient Name:	Date:
Partners Name:	Birthdate:

How long have you been trying to conceive?

Do you have a partner? ☐ Yes ☐ No

Have either of you had children with another partner? ☐ Yes ☐ No

Have you had a fertility workup? ☐ Yes ☐ No

Please check all that apply:

- ☐ CD 2 or 3 Hormone Panel (FSH,/E2/AMH)
- ☐ Luteal Phase Progesterone
- ☐ Prolactin
- ☐ Ultrasound to evaluate uterine lining, antral follicles, ovulation
- ☐ HSG to evaluate fallopian tubes
- ☐ Thyroid Evaluation
- ☐ Endometrial Biopsy/function test
- ☐ Antisperm Antibodies
- ☐ Autoimmune panel
- ☐ Blood Clotting factors
- ☐ Genetic Testing

Was there a diagnosis?____

**If possible please bring copies of any test results with you to your appointment*

Check all that apply:

- ☐ Douche regularly
- ☐ Use vaginal lubricants incl. saliva
- ☐ More than 20% over or under your ideal body weight
- ☐ Excessive facial hair
- ☐ oily skin
- ☐ Excessive loss of head hair
- ☐ Nipple discharge
- ☐ Eating disorder now or in the past
- ☐ low sexual energy
- ☐ Pain during intercourse
- ☐ Erectile Dysfunction

Was your mother exposed to DES or use any medication to prevent a miscarriage while pregnant with you? ☐ Yes ☐ No

Do you know at what age your mother went through menopause?

Have any of your family members had any of the following:

- ☐ Autoimmune Diseases
- ☐ Fertility Issues
- ☐ Clotting Disorders
- ☐ Obesity
- ☐ Thyroid Conditions
- ☐ Prostate Issues
- ☐ Osteoporosis
- ☐ Diabetes

Have you been exposed to any known environmental toxins? ☐ Yes ☐ No

Patient Name:	Date:

If you or your partner are taking any medications please be sure to provide an accurate list including over counter medications and medications for cosmetic purposes on page 3 of the New Patient Intake form.

Have you or your partner had a semen analysis*? ☐ Yes ☐ No   When ________

Volume ________ Count ________ Morphology ________ Motility ________

**If possible please bring copies of test results with you to your appointment*

Check if the male partner has had any of the following procedures:

☐ Vastectomy ☐ Vastectomy Reversal Date: ________ ☐ Varicocele Repair Date: ________

HISTORY OF TRYING TO CONCEIVE (TTC) AND FERTILITY TREATMENTS

Please list below all fertility approaches tried:

☐ Natural Timed Intercourse How long did you TTC naturally? ________________________________

☐ Did you use an ovulation predictor, take basel temp or use any other indicators? ☐ Yes ☐ No

Please list history of all fertility treatments:

1. Clomid or other medication to promote ovulation and TTC naturally
2. IUI without Medication
3. IUI with Medication
4. IVF include all cycles
5. Mini IVF (low dose medication)

TREATMENT	WHEN	NAME OF GYN., NP OR RE	RESULT

What is your next step?

Anything else we should know about your fertility journey?