

7969 Engineer Road, Suite 209 • San Diego, CA 92111 • Phone: (858) 495-0771 • Fax: (858) 495-0772 • www.sdhealthylife.com

Patient _____ Date _____

Please answer the following questions even if you have encountered the same question in a previous form. Do not answer questions if indicated for your acupuncturist to fill. Your answers are important as they will help us determine your diagnosis and treatment plan to most effectively enhance your reproductive health.

Do you have a single partner with whom you have been trying to conceive? Yes No

How long have you been trying to conceive together? _____

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

Has he had a fertility workup? Yes No

What were the results? _____

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

Have you taken oral contraceptives? Yes No

Period(s) of use _____

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Please list below all pregnancies and fertility treatments (include cancelled cycles).

Date	Natural, IUI, IVF, ICSI, other	Medications used	# of mature eggs	Pregnancy achieved? Yes/No	If miscarried, indicate at which week	Additional Comments

KidYinXu	Yes	No	Don't Know
Do you have knee problems or lower back weakness, soreness, or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ringing in your ears or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your midcycle fertile cervical mucus scanty or missing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – no coating, shiny, peeled (for acupuncturist to fill)	<input type="checkbox"/>	<input type="checkbox"/>	

KidYangXu	Yes	No	Don't Know
Do you have lower back pain premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early in the morning because you have to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine diluted and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel cramps during your period that respond to a heating pad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – pale, moist, swollen (for acupuncturist to fill)	<input type="checkbox"/>	<input type="checkbox"/>	

SpQiXu	Yes	No	Don't Know
Are you often tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse, or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't Know
Are you more tired around ovulation or menstruation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period comes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complexion – pale, yellowish (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue – swollen, teeth marks (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

XueXu	Yes	No	Don't Know
Are your menses scanty and/or late?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing hair on your head (not in patches, but all over)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lips, the inner side of your lower eyelids, or tongue pale (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

XueYu	Yes	No	Don't Know
Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel midcycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience periodic numbness of your hands and feet (especially at night)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have red hemangiomas (cherry-red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and “sooty”?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender with pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abnormal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – dark, dark spots, veins (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

LivQiYu	Yes	No	Don't Know
Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated or irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it feel as if your ovulation lasts longer than it should?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distention or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't Know
Do you become bloated premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark, or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – dark, purplish (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

HtXu	Yes	No	Don't Know
Do you wake up early in the morning and have trouble getting back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking vitality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – red tip, center crack to tip (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

ShiHeat	Yes	No	Don't Know
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating or have hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially premenstrually)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a short menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse – rapid (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

Damp	Yes	No	Don't Know
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or pus-filled acne?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have urgent, bright, or foul-smelling stool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain stringy tissue or mucus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue – wet, slimy (for acupuncturist)	<input type="checkbox"/>	<input type="checkbox"/>	

DampHeat	Yes	No	Don't Know
Do you have foul-smelling, yellow, or greenish vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to vaginal and/or rectal itching premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For acupuncturist)

ColdUterus

KidYangXu

XueYu

Cool abdomen

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>