Amy Lucarelli Acupuncture & Herbal Medicine

I'd like to review your blood work. If you feel comfortable sharing that with me, please bring with you a copy or I'll make a copy of your most recent blood work.

Name_____ Date_____

Parental history: How many siblings were in your mother and father's family and what was their age span and what number child was she/he? Also were your mother and father healthy at the time of your birth?

Mother_____#number of miscarriages_____

Father _____

Were your mother and father healthy at the time of your birth?_____

Onset of Menses _____ Duration_____ Days between Cycle _____

What was your flow like during the first few years _____

_____

LMP _____ Any Concerns _____

What is a typical flow like, number of pads/tampons size/saturation)energy/mood/cravings

_____

PMS energy/mood/cravings? _____

Clotting/Size _____ Color _____ Cramps _____

Number of lives births. _____dates_____ dates_____ dates_____ dates_____ dates_____

Miscariges _____ Date/dates _____any complications _____

Menopause date _____ What was the transition like entering menopause?

Describe _____

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Sexual Activity:
How is your Libido? (Your desire for sex) circle one: non existent, poor, consistent, strong
Do you initiate sexually with your partner? Yes / No How many times per week or month?_____

If you don't initiate sexual activity within your relationship,
how many times are you having sexual intercourse a week or month?_____

Is there a need for outside lubricants? **Yes or No** Do you use any of these as lubricants in Sexual intercourse? KY Jelly, Vaseline, Saliva

If you have taken Birth Control Pills, when and
for how long did you take them?_____

Any sexually transmitted diseases _____

PID _____ Date of last OBGYN visit/pap _____

Western Medical Diagnosis for infertility: _____

Name of OBGYN Physician: _____

Address of OBGYN:_____

Name of Fertility Physician: _____

Name of Fertility Clinic: _____

GYN related Surgeries: (dates and outcome)_____

_____

Any history of Fibroids, Ovarian/Uterine/Breast Cancer, dates _____

_____

Western Tests:
Have you had any of these tests done, if yes please circle and provide results.((usually ordered on the

Hysterosalpingogram (HSP)_____

Endometrial Biopsy _____

Clomid Challenge _____

Follicle Stimulating Hormone _____

Leutinizing Hormone _____

Estradiol _____

Progesterone _____

Prolactin _____

Other tests: _____

_____

In the spaces provided or on back of this page, please indicate and treatment you have received for Assisted Reproductive Technologies. Include: date, type of procedure, medications uses, how your body responded, (egg number, egg quality, number of cells, unwanted side effects, etc..) and the results.

Intrauterine Insemination (IUI)

In Vitro Fertilization

Gamete Intrafallopian Transfer (GIFT) & Zygote Intrafallopian Transfer

Male Factor

Sperm count (number/cc) _____

Sperm Motility (% moving) _____

Sperm Morphology _____

Other past treatments conventional or alternative

Additional comments or concerns you'd like to discuss please describe below.