MOSS
ACUPUNCTURE
415 Spruce Street, San Francisco, California 94118 | 415-244-4412 | www.mossacupuncture.com

Date / /	First Name	Last Name	Middle Initial

Date of Birth / /	Age	Body Type	Height:	Weight:	Occupation:

LMP: _____ Cycle Duration _____

Reproductive Endocrinologist: _____ Start Date: _____ Month/ Year
Other OBGYN doctor _____ Start Date: _____ Month/ Year

Other RE & Clinic _____ Start Date: _____ Month/ Year

Western Diagnosis _____

1. Fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

2. Diagnostics / Date

Elevated FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level	Antisperm Antibodies

Others:

3. If you have PCOS, are you taking:

Glucophage	Fortamet/Metformin	How long?	Are you taking extra B-Complex Vitamins?

4. Female Health:

PID	Chlamydia	STD's	Herpes	Other STD's

5. Procedures performed cont. / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

6. Lab Results/ Dates

FSH Level Day 3	HCG	Prolactin	TSH	T3:	T4:	Free T4:	Others

7. Lab Results Available? **Y / N**

8. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens Plus	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

9. Planned ART / Date:

IUI w/ Injectables	IUI w/ Oral Meds	Clomid	IVF	PGD	Other

10. Fertility History / Dates

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

11. Other:

Age at which menses began? _____
OCP (Birth Control Pill) _____ How long? _____
List name of birth control _____
How long have you been trying to conceive? _____
Clomid challenge test? _____
Date:_____
Day 3_____ at Day 10_____ at _____(month/year)
Recurrent yeast infections? _____ How often? _____

Natural Ovulation …….. Y / N
Which day of your cycle _____ to _____
Typically, how many days are there from one period to the next _____ to _____ days?

Today is which day of patient's cycle? _____

Current month treatment plan _____
(Natural, IUI, IVF, Any Tests, etc.)

12. PMS

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

13**. Menstrual History**

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

14. Is partner currently being treated by us? **Y / N**

Partner's Name _____

Western Diagnosis of the partner: _____

15. Are labs / sperm analysis available? **Y / N**

16. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

17. Male Reproductive History/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / DNA	Anti- Sperm Antibodies	Others

18. Tracking your Fertility :

Basal Body Temperature Chart Y / N
Timed Sex …… Y / N

Ovulation

LH Sticks …… Y / N
OPK …… Y / N