

Acupuncture • Herbal Medicine • Massage • Yoga and so much more!

Kali Sampson-Alexander, LAc, MTOM

4307 S. Crenshaw Blvd.

Los Angeles, CA 90008

323.295.6887 or 323.29.LOTUS

WOMEN'S HEALTH AND FERTILITY FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By providing complete and detailed information of your health history, you help to significantly increase positive outcomes in your treatment.

Answer all questions even if you have encountered the same or similar questions in previous forms. In holistic medicine we treat the root and the branch—the underlying cause of disease as well as the symptoms or expression.

Therefore, a complete health history is required to uncover your constitutional disposition.

From here we create a treatment plan designed specifically for you. Complete this questionnaire as thoroughly as possible. Print all information and indicate areas that you are unclear about with a question mark.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many days do you typically bleed? \_\_\_\_\_  
How heavy is the bleeding?  Light on days \_\_\_\_\_  
 Normal on days \_\_\_\_\_  Heavy on days \_\_\_\_\_

What color is the blood?  
Light Red—What days? \_\_\_\_\_  
Bright Red—What days? \_\_\_\_\_  
Dark Red—What days? \_\_\_\_\_  
Purplish Red—What days? \_\_\_\_\_  
Brown—What days? \_\_\_\_\_  
Black—What days? \_\_\_\_\_

Is there clotting?  
If yes, size and color of clots?

\_\_\_\_\_  
On what days? \_\_\_\_\_  
Color of clots (eg, red, dark red, purplish, etc.)  
\_\_\_\_\_

MENSTRUAL & GYNECOLOGICAL HISTORY

Are you currently pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

Age when MENSES BEGAN \_\_\_\_\_

Age when MENSES STOPPED \_\_\_\_\_

Date of LAST MENSTRUAL PERIOD \_\_\_\_\_

# days from day 1 to day 1 of your period \_\_\_\_\_

Are your periods regular?  Yes  No

Are your periods painful?  Yes  No

How many days does the pain last? \_\_\_\_\_

Explain what days you have pain and the intensity and nature of pain (eg, dull, aching, stabbing, pulling, etc.)  
\_\_\_\_\_

Do you have loose stools at the beginning of your period?  Yes  No

Do you retain water during your period?  
 Yes  No

Check all that you experience BEFORE YOUR PERIOD:

- Tension  Irritability  Anger  Short-temper
- Breast tenderness  Skin outbreaks  Pelvic Pain/Cramps
- Drop in energy  Headaches
- Heat Sensation  Depression  Crying  Sadness

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- Insomnia
- Low back pain
- Pebble-like stools
- Constipation
- Headaches
- Dry Skin/Nails/Lips
- Ringing in ears (tinnitus)
- Feeling of emotional instability
- Cravings

- Dry skin/nails/hair
- Dry eyes or Blurry vision
- Visual disturbances

Check all that you experience **AFTER YOUR PERIOD:**

- Headaches
- Fatigue
- Cold Sensation in pelvis/Lower abdominal region
- Hip pain
- Dry skin/nails/lips
- Cold sensation in low back
- Hot flashes
- Night sweats
- Insomnia
- Constipation
- Irritability
- Headaches
- Loose Stools
- Ringing in ears
- Drop in energy
- Lightheadedness or dizziness
- Depression
- Crying
- Sadness
- Weakness or soreness in knees, hips, or low back
- Feeling of emotional instability
- Cravings

Have you or are you currently taking any medications, herbs, or supplements for any gynecological conditions?  Yes  No

If yes, indicate what you are taking, dosage, frequency, and length of time you were or are currently taking the medication, herbs, or supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your menstrual cycle changed since it began (eg, change in blood flow, change in length of time from day 1 of period to day one of next, etc.)?

- Yes  No

How? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an abnormal pap smear?

- Yes  No

If yes, what year(s)? \_\_\_\_\_

Date of your last pap smear: \_\_\_\_\_

Do you have a family history of any of the following cancers (circle all that apply)?

Breast      Ovarian      Cervical

Other, please indicate: \_\_\_\_\_  
\_\_\_\_\_

**Please check all that you experience if you are (1) no longer bloodletting, (2) experience months between periods, (3) over the age of 35, or (4) recently given birth:**

- Mood swings
- Night sweats
- Facial flushing
- Hot Flashes
- Mental confusion
- Cravings
- Warm sensation in palms, soles of feet, and/or center of chest
- Ringing in ears/tinnitus
- Headaches at crown of head

Have you ever had (please circle): cervical biopsy, cauterization, myomectomy, or fibroid embolization? What year(s)? \_\_\_\_\_

Complications?  Yes  No

Explain: \_\_\_\_\_

Have you ever had a venereal disease?  Yes  No

Have you ever tested positive for HIV?  Yes  No

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If yes, are you receiving treatment?

Yes  No

What treatment are you receiving?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, what was removed and what year(s) was the procedure?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with Chlamydia?

Yes  No

Have you ever been diagnosed with herpes?

Yes  No

Do you ever experience sores or ulcers on your genitalia?  Yes  No

Do you have chronic vaginal discharge?  Yes  No

If yes, is the color (check all that apply):  clear

white  yellow  brown

pink  blood-streaked

other \_\_\_\_\_

Have you ever had pelvic inflammatory disease (PID)?

Yes  No What year? \_\_\_\_\_

Were you treated for it?  Yes  No

How? \_\_\_\_\_

Have you had tubal ligation (tubes tied)?  Yes  No

No

If yes, what year? \_\_\_\_\_ Complications?

Please explain any complications.

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with uterine fibroids?

Yes  No What year? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you ever been diagnosed with endometriosis?

Yes  No What year? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you ever been diagnosed with HPV (Human Papiloma Virus)?  Yes  No What year? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you ever been diagnosed with genital warts?

Yes  No What year? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you been diagnosed with ovarian cysts?

Yes  No What year? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you had a full or partial hysterectomy including removal of uterus, ovaries, cervix, or fallopian tubes?

Yes  No

Have you ever been diagnosed with pelvic adhesions?

Yes  No

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Did you receive treatment?  Yes  No

What treatment? \_\_\_\_\_

Have you had, or do you currently have, any gynecological cancers (eg, ovarian, cervical, uterine, etc)?  Yes  No If yes, what type of cancer and what stage?  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an intravaginal ultrasound?

Yes  No What year? \_\_\_\_\_ What were the findings? \_\_\_\_\_  
\_\_\_\_\_

Are you, or did you, receive treatment?  Yes  No  
What treatment?  
\_\_\_\_\_  
\_\_\_\_\_

BREAST HEALTH

What type(s) of bras, if any, do you wear and how often do you wear one?  
\_\_\_\_\_

Are you currently receiving treatment?  Yes  No

If you are currently receiving treatment, where are you in the treatment process? \_\_\_\_\_  
\_\_\_\_\_

Do you perform regular breast self-exams?  Yes  No

Have you or breastfed or all you currently breast-feeding?  Yes  No If yes, what years and for how long?  
\_\_\_\_\_  
\_\_\_\_\_

If you were diagnosed with gynecological cancer, are you currently cancer free?  Yes  No  Don't know

Have you ever been diagnosed with any other pelvic abnormalities or gynecological conditions?

Yes  No If yes, what condition(s)? \_\_\_\_\_  
\_\_\_\_\_

If you are currently breastfeeding, is your milk in ample supply?  Yes  No

Have you had a mammogram?  Yes  No If yes, what year? \_\_\_\_\_ What were the findings?  
\_\_\_\_\_  
\_\_\_\_\_

What year(s)? \_\_\_\_\_

Did you receive treatment?  Yes  No

What treatment(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a breast ultrasound or CT scan?

Yes  No If yes, what year? \_\_\_\_\_ What were the findings? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Have you had breast thermography?
If yes, what year? \_\_\_\_\_ What were the findings?

\_\_\_\_\_
\_\_\_\_\_

Do you have fibrocystic breasts? [ ]Yes [ ]No
Do you have sebaceous cysts on your breasts?
[ ]Yes [ ]No

Do you have breast ulcers, abscesses, or lumps?
[ ]Yes [ ]No

Have you had a lumpectomy? [ ]Yes [ ]No
If yes, what year(s)? \_\_\_\_\_

Have you had a mastectomy? [ ]Yes [ ]No
If yes, was it due to: Breast Cancer? [ ]Yes [ ]No
Prophylactic? [ ]Yes [ ]No Other? [ ]Yes [ ]No
If Prophylactic or Other, please explain

\_\_\_\_\_
\_\_\_\_\_

Have you had or do you currently have breast cancer? [ ]Yes [ ]No
If yes, what type of breast cancer and what stage? \_\_\_\_\_

Are you, or did you, receive treatment? [ ]Yes [ ]No
What treatment? \_\_\_\_\_

\_\_\_\_\_

Are you currently receiving treatment for breast cancer? [ ]Yes [ ]No

If you are currently receiving treatment, where are you in the treatment process? \_\_\_\_\_

\_\_\_\_\_

If you were diagnosed with breast cancer, are you currently cancer free? [ ] Yes [ ] No [ ] Don't know

FERTILITY HISTORY

Do you know when you ovulate? [ ] Yes [ ] No
If yes, what are the signs of your ovulation?

\_\_\_\_\_
\_\_\_\_\_

On what day of your cycle do you ovulate? \_\_\_\_\_

Do you experience ovulatory breast tenderness? [ ] Yes [ ] No [ ] Don't know

How many pregnancies have you had? \_\_\_\_\_
What year(s)? \_\_\_\_\_

How many live births have you had? \_\_\_\_\_
What year(s)? \_\_\_\_\_
Any complications? Explain

\_\_\_\_\_

How many vaginal births? \_\_\_\_\_
What year(s)? \_\_\_\_\_

How many Caesarean Sections/C-Sections? \_\_\_\_\_
What year(s)? \_\_\_\_\_

How many stillbirths? \_\_\_\_\_
What year(s)? \_\_\_\_\_

How many miscarriages? \_\_\_\_\_
What year(s)? \_\_\_\_\_

How many abortions? \_\_\_\_\_
What year(s) \_\_\_\_\_

How many times has a D&C been performed? \_\_\_\_\_

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What year(s)? \_\_\_\_\_

Any complications? Yes No

Have you ever had an episiotomy? Yes No

What year(s)? \_\_\_\_\_

Complications? Yes No

If you are attempting to get pregnant, how long have you been trying to conceive? \_\_\_\_\_

Do you have a family history of infertility? Yes No

Have you had fertility treatments? Yes No

If yes, when and where?

\_\_\_\_\_

\_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

\_\_\_\_\_

Results? \_\_\_\_\_

\_\_\_\_\_

Do you ovulate without the use of artificial hormonal aids, medications, or supplements/herbs?

Yes  No

If no, please indicate what you are taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have your fallopian tubes been evaluated medically? Yes No If yes, what were the findings?

\_\_\_\_\_

\_\_\_\_\_

Have you had any hormone laboratory tests performed? Yes No

What were the findings?

\_\_\_\_\_

\_\_\_\_\_

Is your partner supportive of your wish to conceive?

Yes No

Have you ever taken oral contraceptives? Yes No

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had an IUD? Yes No

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever taken DepoProvera?

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had a diagnosis relating to infertility?

Yes No What was it? \_\_\_\_\_

How is your sexual energy? \_\_\_\_\_

\_\_\_\_\_

Is sexual intercourse painful? Yes No

Are you currently sexually active? Yes No

Do you find sex pleasurable? Yes No

Are you experiencing any sexual problems?

Yes No

Does your partner experience any sexual dysfunction? Yes No

\_\_\_\_\_

Do you douche regularly? Yes No

With what? \_\_\_\_\_

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more that 20% below your ideal body weight?

Yes No

Do you have a stressful occupation? Yes No

