

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

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

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- Lightheadedness or dizziness
- Depression
- Crying
- Sadness
- Weakness or soreness in knees, hips, or low back
- Feeling of emotional instability
- Cravings

Have you ever had an abnormal pap smear? Yes No

If yes, what year(s)? _____

Date of your last pap smear: _____

Has your menstrual cycle changed since it began (e.g., change in blood flow, change in length of time from day 1 of period to day one of next, etc.)? Yes No

How? _____

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

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

If yes, are you receiving treatment? Yes No

What treatment are you receiving? _____

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 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:

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

If yes, what year? _____ Complications? Yes No

Please explain any complications.

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

Yes No

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

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 Papilloma 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 ever been diagnosed with pelvic adhesions?

Yes No

Did you receive treatment? Yes No

What treatment? _____

Have you had, or do you currently have, any gynecological cancers (e.g., ovarian, cervical, uterine, etc)?

Yes No If yes, what type of cancer and what stage?

Are you, or did you, receive treatment? Yes No

What treatment? _____

Are you currently receiving treatment? Yes No

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

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)? _____

What year(s)? _____

Did you receive treatment? Yes No

What treatment(s)? _____

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Have you had breast thermography?
If yes, what year? _____ What were the find-
ings? _____

Have you ever had an intravaginal ultrasound?
 Yes No 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

BREAST HEALTH

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

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

Do you perform regular breast self-exams? Yes No
Have you or breastfed or all you currently breastfeed-
ing? Yes No If yes, what years and for how long?

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

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

Are you, or did you, receive treatment? Yes No
What treatment? _____

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

Are you currently receiving treatment for breast can-
cer? Yes No

Have you had a breast ultrasound or CT scan?
 Yes No If yes, what year? _____ What
were the findings? _____

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

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

What year(s)? _____
Complications? _____

FERTILITY HISTORY

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

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?

On what day of your cycle do you ovulate? _____

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

By whom? _____

What types? _____

How many pregnancies have you had? _____

What year(s)? _____

Results? _____

How many live births have you had? _____

What year(s)? _____

Any complications? Explain _____

Do you ovulate without the use of artificial hormonal aids, medications, or supplements/herbs? Yes No

If no, please indicate what you are taking:

How many vaginal births? _____

What year(s)? _____

How many Caesarean Sections/C-Sections? _____

What year(s)? _____

Have your fallopian tubes been evaluated medically?

Yes No If yes, what were the findings? _____

How many stillbirths? _____

What year(s)? _____

Have you had any hormone laboratory tests performed? Yes No

What were the findings?

How many miscarriages? _____

What year(s)? _____

How many abortions? _____

What year(s)? _____

How many times has a D&C been performed? _____

What year(s)? _____

Any complications? _____

Is your partner supportive of your wish to conceive?

Yes No

Have you ever had an episiotomy? Yes No

Have you ever taken oral contraceptives? Yes No

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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 than 20% below your ideal body weight?

Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Have you experienced excessive loss of hair on your

head? Yes No

Do you have excessively oily skin? Yes No

Have you noticed discharge from your nipples?

Yes No

Was your mother exposed to diethylstilbestrol (DES)

when she was pregnant with you? Yes No

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

Are you presently taking steroids? Yes No

Please provide a complete list of all medications, herbs, supplements, etc. you are currently taking that you have not previously listed in this questionnaire. Indicate dosage and frequency.

Are there any other gynecological concerns that were not addressed in this questionnaire?

If so, please use the space below or the back of this page to explain.