CLINIQUE ASIATIQUE

NAME (LAST, FIRST, MIDDLE)	AGE	DATE

Date of birth _____
Age at which menses began _____
Date of last menstrual period _____

MENSTRUATION:
Are your menstrual cycles regular? ☐ yes ☐ no
Average # of days in your cycle _____
How many days do you normally bleed? _____
Have your cycles changed since they began?
☐ yes ☐ no
How? _____

Are your periods painful? ☐ yes ☐ no
How many days does the pain last? _____
Do you take medication for the pain? ☐ yes ☐ no
When does the pain occur?
☐ prior to period ☐ during ☐ after period
Intensity of pain: ☐ mild ☐ moderate ☐ severe
Location of pain:
☐ midline ☐ right side ☐ left side
How heavy is the bleeding?
☐ light ☐ normal ☐ heavy
What color is the blood?
☐ light red ☐ red ☐ dark red ☐ brown
Blood consistency: ☐ watery ☐ thin ☐ thick
Are there clots? ☐ yes ☐ no

Do you have PMS? ☐ yes ☐ no
Do you break out before or during your period? ☐ yes ☐ no
Do your breasts become tender before or during your period?
☐ yes ☐ no
Do you experience water gain/bloating?
☐ prior to period ☐ during ☐ after period

Do your bowel movements become loose at the beginning of your period? ☐ yes ☐ no
Are you able to tell when you ovulate? ☐ yes ☐ no
On what day of your cycle? _____
Do you bleed or spot between periods? ☐ yes ☐ no

What is your stress level? ☐ low ☐ moderate ☐ severe
Do you exercise? ☐ yes ☐ no
Type _____ hrs/week _____
Type _____ hrs/week _____

CONTRACEPTIVE USE:

Type	How long	Reason discontinued

Primary GYN: _____
Tel #: _____

PREGNANCY HISTORY:
# of pregnancies: _____
Any pregnancy complications? _____
_____
# of live births: _____
# of miscarriages: _____
☐ during 1st trimester ☐ later in pregnancy
# of abortions: _____
How many times has a D&C been performed? _____

GYNECOLOGIC/INFECTIONS:
Do you get yeast infections regularly? ☐ yes ☐ no
Do you have chronic vaginal discharge? ☐ yes ☐ no
If yes, color: _____
Odor: _____

Have you ever been diagnosed with (please check):

	Yes	No
Chlamydial or gonorrheal infection		
Uterine fibroids or polyps		
Endometriosis		
Pelvic inflammatory disease		
Pelvic adhesion		
Ovarian cysts		

Date of last pap smear _____
Have you ever had an abnormal pap smear?
☐ yes ☐ no
If yes, what type? _____
How treated? _____

Date of last mammogram _____
Do you do regular breast exams? ☐ yes ☐ no
Have you ever had breast discharge? ☐ yes ☐ no

How would you describe your sexual energy?
☐ low ☐ normal ☐ high
Do you have pain with intercourse?
☐ never ☐ sometimes ☐ frequently ☐ always
If yes, does the pain remain in your lower abdomen after intercourse is over? ☐ yes ☐ no
If yes, for how many minutes? _____

570 Price Avenue, Suite 100, Redwood City, CA 94063
140 Clark Drive, San Mateo, CA 94402
Tel: 650.513.1712
www.cliniqueasiatique.com

FERTILITY EVALUATION:

How long have you & your partner been trying to conceive?
_____

Have you been using temperature charts? ☐ yes ☐ no
If yes, for how long? _____

Have you been using ovulation predictor kits? ☐ yes ☐ no
If yes, what kind & for how long? _____
_____

Have you ever tried to achieve a pregnancy with a different partner? ☐ yes ☐ no

Have you ever conceived with a different partner?
☐ yes ☐ no

Has your male partner ever gotten someone else pregnant?
☐ yes ☐ no

HISTORY OF FERTILITY THERAPY:

Have you had a diagnosis relating to fertility?
☐ yes ☐ no
What was it? _____
_____

Have you had surgery on your reproductive organs?
☐ yes ☐ no
If yes, what type? _____
_____

Have you had fertility treatments? ☐ yes ☐ no
If yes, when & where? _____
By whom? _____
Fertility center: _____
Tel #: _____
What types? _____
_____

IUI cycles: (please attach additional pages if necessary)

Dates	Meds	Outcome

IVF cycles: (please attach additional pages if necessary)

Dates	Meds	Outcome

Have you had an HSG (hysterosalpingogram) dye study of your fallopian tubes?
☐ yes ☐ no If yes, when? _____
What were the results? _____

Have you had any hormone tests performed? ☐ yes ☐ no
What were the results?

- FSH: ☐ low ☐ normal ☐ high
  Value: _____ When? _____
- TSH: ☐ low ☐ normal ☐ high
  Value: _____ When? _____
- Estradiol: ☐ low ☐ normal ☐ high
  Value: _____ When? _____

Do you have a single partner with whom you have been trying to conceive? ☐ yes ☐ no
How long have you been married or living together?
_____
How frequently do you & your partner have intercourse?
_____
Do you use vaginal lubricants? ☐ yes ☐ no
What type? _____
Has he had a semen analysis? ☐ yes ☐ no
When? _____

- Sperm count: ☐ below normal ☐ normal
- Morphology: ☐ below normal ☐ normal
- Mobility: ☐ below normal ☐ normal

Current weight: _____ Height: _____
Are you more than 10 lbs over your ideal body weight?
☐ yes ☐ no
Are you more than 10 lbs below your ideal body weight?
☐ yes ☐ no

Do you have excessive facial hair? ☐ yes ☐ no
Do you have excessively oily skin? ☐ yes ☐ no
Have you experienced excessive loss of head hair?
☐ yes ☐ no
Are you presently taking oral steroids? ☐ yes ☐ no
Are you presently taking anticoagulants? ☐ yes ☐ no

Please list any supplements you have taken to enhance fertility: (please attach additional pages if necessary)

Type	How long	Noticeable result(s)