MADISON ACUPUNCTURE & COMPLEMENTARY MEDICINE
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FEMALE FERTILITY

Have you had any hormone testing done? (e.g., Day 3, Day 21)			
FSH ……..	Low___	Normal___	High___
Estrogen (E2) ……..	Low___	Normal___	High___
Progesterone ……..	Low___	Normal___	High___
Prolactin ……..	Low___	Normal___	High___
Thyroid (TSH) ……..….	Low___	Normal___	High___
Testosterone ……..	Low___	Normal___	High___
Other _____	Low___	Normal___	High___

Do you currently have a partner? Yes___ No___

If yes, what is your partner's name? _____

Is your partner supportive of your wishes to conceive? _____

How long have you been trying to conceive? _____

Have you had a Western medical diagnosis relating for fertility? Yes___ No___

If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? Yes___ No___

If yes, what was the diagnosis? _____ Who made the diagnosis? _____
Have you taken medication to help you ovulate? Yes___ No___

If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes___ No___

What were the results? _____

Have you had any tubal operations? Yes___ No___

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc.) Yes___ No____

Month/Year	Type of treatment	Clinic	Results

What was your medical response to the fertility treatments? Poor___ Average ____ Good___

Are you using donor sperm? Yes___ No___
If yes, why? (no partner, female partner, male partner has semen issues, etc.) _____

Are you using donor eggs or embryos? Yes___ No___
How is your sexual desire (mental interest)?..... Low___ Normal___ High___
How is your sexual arousal (physical/orgasm)?..... Low___ Normal___ High___
Do you use vaginal lubricants?..... Yes___ No___
Have you been exposed to or received chemotherapy or radiation? … Yes___ No___
Do you have excessive facial or body hair? …….. Yes___ No___
Do you have excessively oily skin or acne? …… Yes___ No___

Please print, complete, and bring forms to your initial appointment. Thank you.

Patient Information Release Request Form

I,_____ (please print name), give full consent so that Madison Acupuncture & Complementary Medicine may consult freely with other physicians and healthcare professionals (whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(*to be filled out by your practitioner*)

The following is an authorization to provide Madison Acupuncture & Complementary Medicine with the following information:

- ○ All recent lab work results
- ○ All medical records
- ○ All semen tests
- ○ Other: _____

I am eighteen years of age or older (circle one):

- ○ Yes
- ○ No

Client/Patient Signature:_____ Date:_____

Signature of parent or guardian (if applicable): _____

Thank you for your prompt attention to this request. Please bring information or email to Amy@MadisonAcupunctureMedicine.com. If you have any questions, please feel free to contact us.

Madison Acupuncture & Complementary Medicine, LLC