425 Old Newport Blvd, Suite E, Newport Beach, CA 92663

T. (949) 723-0054 F. (949) 723-6129 info@leeacupuncture.com

Fertility Patient Information Form

Patient Name: _______________________________ Age: ________Years trying to conceive:_______

Current Diagnosis

Number of	
Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Failed IUI's	
Failed IVF's	

Occupation: ____

Hobbies / Interests: ____

Partner: ____________________ Occ: ____________________ Age:______

Male Factor: ____

Children: Name(s)/Age(s): _______________________________________

Important Clinical Notes:

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Western Diagnosis for Infertility: ____

OB/GYN: _____________________________________ R.E._______________________________________

Major Fertility Signs and Symptoms: ___________ Cycle Days ___________ Days of Bleeding

Regular / Erratic: ______________ Clotting: __________________ Spotting: ______________________

PMS Signs: ______________________________________ Pain: _________________________________

Cervical Mucus: ____________________________ Ovulation: __________________________________

Color of Blood: ______________________________

Notes:

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Practitioner: ____ Date:___________________________

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