the caporale center of natural health
Dr. Kym Black-Caporale, MS DOM ▪ Acupuncture Physician
ofc 727.521.0210 ▪ fax 727.521.0211 ▪ www.livewelltampabay.com

**CONFIDENTIAL**

# women's fertility history I

| NAME (LAST, FIRST, MIDDLE) | | DATE |
|---|---|---|
| WEIGHT | HEIGHT | AGE |

| AGE AT WHICH MENSES BEGAN | HAVE YOUR CYCLES CHANGED SINCE THEN? IF SO, HOW? |
|---|---|

| ARE YOUR PERIODS PAINFUL? | HOW LONG DOES THE PAIN LAST? | HOW MANY DAYS DO YOU NORMALLY BLEED? | HOW MANY DAYS BETWEEN YOUR PERIODS? | DATE OF LAST MENSTRUAL PERIOD | DATE OF LAST PAP SMEAR: |
|---|---|---|---|---|---|
| | | | | | |

**HOW HEAVY IS THE BLEEDING?**
*Fill in the chart.*

HEAVY
NORMAL
LIGHT

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

DAY

**WHAT COLOR IS THE BLOOD?**
*Fill in the chart.*

LIGHT RED
RED
DARK RED
PURPLE
BROWN
BLACK

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

DAY

| *Please answer yes or no to best describe your current condition.* | YES | NO |
|---|---|---|
| DO YOU EXPERIENCE CLOTTING? | ☐ | ☐ |
| DO YOU HAVE PREMENTRUAL TENSION / PMS? | ☐ | ☐ |
| DOES YOUR FACE BREAK OUT BEFORE OR DURING YOUR PERIOD? | ☐ | ☐ |
| ARE YOUR BREASTS TENDER PREMENSTRUALLY? | ☐ | ☐ |
| DO YOU BLEED OR SPOT BETWEEN PEIODS? | ☐ | ☐ |
| ARE YOUR MENSTRUAL CYCLES SPACED IRREGULARLY? | ☐ | ☐ |
| IF SO, PLEASE EXPLAIN: _____ | | |
| ARE YOUR BREASTS TENDER AT / DURING OVULATION? | ☐ | ☐ |
| DO YOU GET PREMENSTRUAL LOW BACK PAIN? | ☐ | ☐ |
| DO YOU EXPERIENCE LOOSE STOOLS AT THE BEGINNING OF YOUR PERIOD? | ☐ | ☐ |

| *Please answer yes, no, or with the number of occurrences.* | YOUR ANSWER | DATE OR YEARS | |
|---|---|---|---|
| HOW MANY PREGNANCIES HAVE YOU HAD? | _____ | _____ | |
| HOW MANY CHILDREN DO YOU HAVE? | _____ | _____ | |
| HOW MANY ABORTIONS HAVE YOU HAD? | _____ | _____ | |
| HOW MANY MISCARRAIGES HAVE YOU HAD? | _____ | _____ | |
| HOW MANY TIMES HAS A D&C BEEN PERFOMRED? | _____ | _____ | HOW LONG? |
| HAVE YOU EVER TAKEN ORAL CONTRACEPTIVES? | _____ | _____ | _____ |
| HAVE YOU EVER TAKEN DEPOPROVERA? | _____ | _____ | _____ |
| HAVE YOU EVER HAD AN IUD? | _____ | _____ | _____ |

the caporale center of natural health
Dr. Kym Black-Caporale, MS DOM ▪ Acupuncture Physician
ofc 727.521.0210 ▪ fax 727.521.0211 ▪ www.livewelltampabay.com

**CONFIDENTIAL**

# women's fertility history II

| NAME (LAST, FIRST, MIDDLE) | DATE |
|---|---|
| | |

*Have you ever been diagnosed with or experienced the following?*

*Please provide the number of occurrences, years / dates they occurred when applicable and any additional information that would be beneficial to the physician in determining your treatment plan.*

| | YES | NO | NUMBER | DATES | ADDITIONAL NOTES / INFORMATION |
|---|---|---|---|---|---|
| ABNORMAL PAP SMEAR | ☐ | ☐ | _____ | _____ | _____ |
| ENDOMETRIOSIS | ☐ | ☐ | _____ | _____ | _____ |
| LOW FSH | ☐ | ☐ | _____ | _____ | _____ |
| PCOS | ☐ | ☐ | _____ | _____ | _____ |
| PELVIC ABNORMALITIES | ☐ | ☐ | _____ | _____ | _____ |
| LOW IRON | ☐ | ☐ | _____ | _____ | _____ |
| ANEMIA | ☐ | ☐ | _____ | _____ | _____ |
| LOW PROGESTERONE | ☐ | ☐ | _____ | _____ | _____ |
| LOW ESTROGEN | ☐ | ☐ | _____ | _____ | _____ |
| PELVIC ADHESIONS | ☐ | ☐ | _____ | _____ | _____ |
| PELVIC INFLAMMATORY DISEASE | ☐ | ☐ | _____ | _____ | _____ |
| UTERINE FIBROIDS | ☐ | ☐ | _____ | _____ | _____ |
| POLYPS | ☐ | ☐ | _____ | _____ | _____ |
| CYSTS | ☐ | ☐ | _____ | _____ | _____ |
| HEP C | ☐ | ☐ | _____ | _____ | _____ |
| GENITAL HERPES | ☐ | ☐ | _____ | _____ | _____ |
| EARLY MENOPAUSE | ☐ | ☐ | _____ | _____ | _____ |
| CHLAMYDIAL INFECTION | ☐ | ☐ | _____ | _____ | _____ |
| VENERAL DISEASE | ☐ | ☐ | _____ | _____ | _____ |
| REGULAR / FREQUENT YEAST INFECTIONS *(provide number per year)* | ☐ | ☐ | _____ | _____ | _____ |
| CHRONIC VAGINAL DISCHARGE | ☐ | ☐ | _____ | _____ | _____ |
| SORES ON GENETALIA | ☐ | ☐ | _____ | _____ | _____ |
| CERVICAL BIOPSY,OPERATION, CAUTERIZATION OR CONIZATION | ☐ | ☐ | _____ | _____ | _____ |

the caporale center of natural health
Dr. Kym Black-Caporale, MS DOM ▪ Acupuncture Physician
ofc 727.521.0210 ▪ fax 727.521.0211 ▪ www.livewelltampabay.com

**CONFIDENTIAL**

# women's fertility history III

| NAME (LAST, FIRST, MIDDLE) | DATE |
|---|---|
| | |

**HOW LONG HAVE YOU BEEN TRYING TO CONCEIVE?** _____

**REPRODUCTIVE ENDOCRINOLOGIST'S NAME (IF APPLICABLE)** _____

**WHICH OFFICE LOCATION DO YOU SEE HIM/HER AT FOR REGULAR APPOINTMENTS?** _____

| | YES | NO | DATE | DESCRIPTION |
|---|---|---|---|---|
| **HAVE YOU HAD A DIAGNOSIS RELATING TO INFERTILITY?** | ☐ | ☐ | _____ | _____ |
| **HAVE YOU HAD FERTIITY TREATMENTS?** | ☐ | ☐ | _____ | _____ |
| **HAVE YOUR FALLOPIAN TUBES BEEN MEDICALLY EVALUATED?** | ☐ | ☐ | _____ | _____ |
| **HAVE YOU HAD ANY TUBAL OPERATIONS?** | ☐ | ☐ | _____ | _____ |
| **HAVE YOU HAD HORMONE LABORATORY TESTS PERFORMED?** | ☐ | ☐ | _____ | _____ |
| **HAS YOUR PARTNER HAD A FERTILITY WORKUP?** | ☐ | ☐ | _____ | _____ |
| **DOES YOUR PARTNER HAVE A DIAGNOSIS RELATING TO INFERTILITY?** | ☐ | ☐ | _____ | _____ |
| **DO YOU OVULATE ON YOUR OWN?** *(If yes, on what day of your cycle?)* | ☐ | ☐ | _____ | _____ |
| **HAVE YOU TAKEN MEDICATION TO HELP YOU OVULATE?** | ☐ | ☐ | _____ | _____ |
| **HAVE YOU HAD ACUPUNCTURE FOR FETILTY?** *(If yes, where?)* | ☐ | ☐ | _____ | _____ |

*Please list the results of the following below or attach copies of you lab reports to this packet.*

**MEDICAL EVALUATION OF FALLOPIAN TUBES**

**TUBAL OPERATIONS**

**HORMONE LABORATORY TESTS**

the caporale center of natural health
Dr. Kym Black-Caporale, MS DOM ▪ Acupuncture Physician
ofc 727.521.0210 ▪ fax 727.521.0211 ▪ www.livewelltampabay.com

**CONFIDENTIAL**

# women's fertility history IV

| NAME (LAST, FIRST, MIDDLE) | DATE |
|---|---|
| | |

ARE YOU CURRENTLY TAKING OR HAVE YOU IN THE PAST TAKEN MEDICATION FOR TREATING INFERTILITY? ☐ YES ☐ NO

HAVE YOU EVER TAKEN / USED HERBS, SUPPLEMENTS, CREAMS, ETC TO ASSIST WITH FERTILITY? ☐ YES ☐ NO

IF YES, WHERE DID YOU LEARN OF THE ABOVE?

_____

DO YOU DOUCHE REGULARLY? ☐ YES ☐ NO

IF YES, WITH WHAT?

_____

DO YOU USE VAGINAL LUBRICANTS? ☐ YES ☐ NO

IF YES, WITH WHAT?

_____

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 OR HOME LIFE? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ 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

HAVE YOU NOTICED DISCHARGE FROM YOUR NIPPLES? ☐ YES ☐ NO

WAS YOUR MOTHER EXPOSED TO 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

DO YOU HAVE A SINGLE PARTNER WITH WHOM YOU ARE TRYING TO CONCEIVE? ☐ YES ☐ NO

IS YOUR PARNTER SUPPORTIVE OF YOUR WISH TO CONCEIVE? ☐ YES ☐ NO

IS YOUR PARTNER TAKING / USING ANY MEDICATIONS, HERBS, SUPPLEMENTS, CREAMS, ETC. TO ASSIST WITH FERTILITY? ☐ YES ☐ NO

WHAT BOOKS HAVE YOU READ ON FERTILITY?

_____

_____

_____

HOW DID YOU LEARN ABOUT ACUPUNCTURE ASSITING FERTILITY?

_____

_____

_____

HOW WERE YOU REFERRED TO THE CAPORALE CENTER OF NATURAL MEDICINE?

_____

PLEASE LIST ANY MEDICATIONS, HERBS, SUPPLEMENTS OR CREAMS YOU ARE TAKING OR HAVE TAKEN TO ASSIST WITH FERTILITY.

| NAME & STRENGTH | CURRENTLY TAKING? | TOTAL DAILY DOSAGE | DATES TAKEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***List any additional on the reverse side of this page.*

PLEASE LIST ANY HERBS, SUPPLEMENTS OR CREAMS YOU ARE TAKING NOT RELATED TO A FERTILITY CONCERN.

| NAME & STRENGTH | HOW LONG? | TOTAL DAILY DOSAGE | DATES TAKEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***List any additional on the reverse side of this page.*

PLEASE LIST ANY MEDICATIONS, HERBS, SUPPLEMENTS OR CREAMS YOUR PARTNER IS CURRENTLY TAKING FOR ALL CONCERNS, INCLUDING FERTILITY.

| NAME & STRENGTH | HOW LONG? | TOTAL DAILY DOSAGE | DATES TAKEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***List any additional on the reverse side of this page.*

*We invite you to share any additional information or concerns in regards to your fertility on a separate sheet of paper and attach it to this packet.*