535 Encinitas Blvd., Suite 115 • Encinitas, CA 92024 • (760) 575-4227 • www.CapWellnessCenter.com

Women's Fertility Symptom Survey

Please answer the following questions even if you have encountered the same question in a previous form. Do not answer questions if indicated for your acupuncturist to fill. Your answers are important, as they will help us determine your diagnosis and treatment plan to most effectively enhance your reproductive health.

Do you have a single partner with whom you have been trying to conceive? □ Yes □ No

How long have you been trying to conceive together? _____

Is your partner supportive of your wish to conceive? □ Yes □ No

Has he had a fertility workup? □ Yes □ No

What were the results? _____

Have you had a diagnosis relating to infertility? □ Yes □ No If so, what was it?

_____

Have you taken oral contraceptives? □ Yes □ No If so, list period(s) of use:

_____

Do you douche regularly? □ Yes □ No If so, with what?

_____

Do you use vaginal lubricants? □ Yes □ No

Please list below all pregnancies and fertility treatments (include cancelled cycles):

Date	Natural, IUI, IVF, ICSI, other	Medications used	# of mature eggs	Pregnancy achieved? Yes/No	If miscarried, indicate at which week	Additional Comments

Please answer the following questions to the best of your ability:

KidYinXu	Yes	No	Don't Know
Do you have knee problems or lower back weakness, soreness, or pain?	☐	☐	☐
Do you have ringing in your ears or dizziness?	☐	☐	☐
Is your hair prematurely gray?	☐	☐	☐
Do you have vaginal dryness?	☐	☐	☐
Is your midcycle fertile cervical mucus scanty or missing?	☐	☐	☐
Do you have dark circles around or under your eyes?	☐	☐	☐
Do you have night sweats?	☐	☐	☐
Are you prone to hot flashes?	☐	☐	☐
Would you describe yourself as afraid a lot?	☐	☐	☐
Tongue – no coating, shiny, peeled (for acupuncturist to fill)	☐	☐	☐

KidYangXu	Yes	No	Don't Know
Do you have lower back pain premenstrually?	☐	☐	☐
Is your low back sore or weak?	☐	☐	☐
Are your feet cold, especially at night?	☐	☐	☐
Are you typically colder than those around you?	☐	☐	☐
Is your libido low?	☐	☐	☐
Are you often fearful?	☐	☐	☐
Do you wake up at night or early in the morning because you have to urinate?	☐	☐	☐
Do you urinate frequently, and is the urine diluted and/or profuse?	☐	☐	☐
Do you have early morning loose, urgent stools?	☐	☐	☐
Do you have profuse vaginal discharge?	☐	☐	☐
Does your menstrual blood tend to be dull in color?	☐	☐	☐
Do you feel cramps during your period that respond to a heating pad?	☐	☐	☐
Tongue – pale, moist, swollen (for acupuncturist to fill)	☐	☐	☐

SpQiXu	Yes	No	Don't Know
Are you often tired?	☐	☐	☐
Do you have poor appetite?	☐	☐	☐
Is your energy lower after a meal?	☐	☐	☐
Do you feel bloated after eating?	☐	☐	☐
Do you crave sweets?	☐	☐	☐
Do you have loose stools, abdominal pain, or digestive problems?	☐	☐	☐
Are your hands and feet cold?	☐	☐	☐
Is your nose cold?	☐	☐	☐
Are you prone to feeling heavy or sluggish?	☐	☐	☐
Are you prone to feeling heaviness or grogginess in the head?	☐	☐	☐
Do you bruise easily?	☐	☐	☐
Do you think you have poor circulation?	☐	☐	☐
Do you have varicose veins?	☐	☐	☐
Are you lacking strength in your arms and legs?	☐	☐	☐
Are you lacking in exercise?	☐	☐	☐
Have you been diagnosed with low blood pressure?	☐	☐	☐
Do you sweat a lot without exerting yourself?	☐	☐	☐
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?			
Is your menstruation thin, watery, profuse, or pinkish in color?	☐	☐	☐
Are you more tired around ovulation or menstruation?	☐	☐	☐
Do you ever spot a few days or more before your period comes?	☐	☐	☐
Have you ever been diagnosed with uterine prolapse?	☐	☐	☐
Are you often sick, or do you have allergies?	☐	☐	☐
Have you been diagnosed with hypothyroid or anemia?	☐	☐	☐
Do you have hemorrhoids or polyps?	☐	☐	☐
Complexion – pale, yellowish (for acupuncturist)	☐	☐	☐
Tongue – swollen, teeth marks (for acupuncturist)	☐	☐	☐

XueXu	Yes	No	Don't Know
Are your menses scanty and/or late?	☐	☐	☐
Do you have dry, flaky skin?	☐	☐	☐
Are you prone to getting chapped lips?	☐	☐	☐
Are your fingernails or toenails brittle?	☐	☐	☐
Are you losing hair on your head (not in patches, but all over)?	☐	☐	☐
Is your hair brittle or dry?	☐	☐	☐
Do you have diminished nighttime vision?	☐	☐	☐
Do you get dizzy or light-headed around your period?	☐	☐	☐
Lips, the inner side of your lower eyelids, or tongue pale (for acupuncturist)	☐	☐	☐

XueYu	Yes	No	Don't Know
Is your menstrual flow ever brown or black in color?	☐	☐	☐
Do you feel midcycle pain around your ovaries?	☐	☐	☐
Do you have painful, unmovable breast lumps?	☐	☐	☐
Do you feel periodic numbness of your hands and feet (especially at night)?	☐	☐	☐
Do you have varicose or spider veins?	☐	☐	☐
Do you have red hemangiomas (cherry-red spots) on your skin?	☐	☐	☐
Does your complexion appear dark and "sooty"?	☐	☐	☐
Do you have chronic hemorrhoids?	☐	☐	☐
Does your menstrual blood contain clots?	☐	☐	☐
Have you been diagnosed with endometriosis or uterine fibroids?	☐	☐	☐
Is your lower abdomen tender with pressure?	☐	☐	☐
Can you feel any abnormal lumps in your lower abdomen?	☐	☐	☐
Do you have piercing or stabbing menstrual cramps?	☐	☐	☐
Do you have dark spots in your eyes?	☐	☐	☐
Diagnosed with any vascular abnormality or blood clotting disorder?	☐	☐	☐
Tongue – dark, dark spots, veins (for acupuncturist)	☐	☐	☐

LivQiYu	Yes	No	Don't Know
Are you prone to emotional depression?	☐	☐	☐
Are you prone to anger and/or rage?	☐	☐	☐
Do you become irritable premenstrually?	☐	☐	☐
Do you feel bloated or irritable around ovulation?	☐	☐	☐
Does it feel as if your ovulation lasts longer than it should?	☐	☐	☐
Are your breasts sensitive/sore at ovulation?	☐	☐	☐
Do you experience nipple pain or discharge from your nipples?	☐	☐	☐
Do you have a lot of premenstrual breast distention or pain?	☐	☐	☐
Have you been diagnosed with elevated prolactin levels?	☐	☐	☐
Do you become bloated premenstrually?	☐	☐	☐
Do you have difficulty falling asleep at night?	☐	☐	☐
Do you experience heartburn or wake up with a bitter taste in your mouth?	☐	☐	☐
Are your menses painful?	☐	☐	☐
Do you feel your menstrual cramps in the external genital area?	☐	☐	☐
Is the menstrual blood thick and dark, or purplish in color?	☐	☐	☐
Tongue – dark, purplish (for acupuncturist)	☐	☐	☐

HtXu	Yes	No	Don't Know
Do you wake up early in the morning and have trouble getting back to sleep?	☐	☐	☐
Do you have heart palpitations, especially when anxious?	☐	☐	☐
Do you have nightmares?	☐	☐	☐
Do you seem low in spirit or lacking vitality?	☐	☐	☐
Are you prone to agitation or extreme restlessness?	☐	☐	☐
Do you fidget?	☐	☐	☐
Do you sweat excessively, especially on your chest?	☐	☐	☐
Tongue – red tip, center crack to tip (for acupuncturist)	☐	☐	☐

ShiHeat	Yes	No	Don't Know
Are your mouth and throat usually dry?	☐	☐	☐
Are you thirsty for cold drinks most of the time?	☐	☐	☐
Do you often feel warmer than those around you?	☐	☐	☐
Do you wake up sweating or have hot flashes?	☐	☐	☐
Do you break out with red acne (especially premenstrually)?	☐	☐	☐
Do you have a short menstrual cycle?	☐	☐	☐
Do you have vaginal irritation or rashes?	☐	☐	☐
Pulse – rapid (for acupuncturist)	☐	☐	☐

Damp	Yes	No	Don't Know
Do you feel tired and sluggish after a meal?	☐	☐	☐
Do you have fibrocystic breasts?	☐	☐	☐
Do you have cystic or pus-filled acne?	☐	☐	☐
Do you have urgent, bright, or foul-smelling stool?	☐	☐	☐
Does your menstrual blood contain stringy tissue or mucus?	☐	☐	☐
Are you prone to yeast infections and vaginal itching?	☐	☐	☐
Do your joints ache, especially with movement?	☐	☐	☐
Are you overweight?	☐	☐	☐
Tongue – wet, slimy (for acupuncturist)	☐	☐	☐

DampHeat	Yes	No	Don't Know
Do you have foul-smelling, yellow, or greenish vaginal discharge?	☐	☐	☐
Are you prone to vaginal and/or rectal itching premenstrually?	☐	☐	☐

(For acupuncturist only)

ColdUterus **KidYangXu** **XueYu** **Cool abdomen**

CAP WELLNESS CENTER

I consent to a complete professional health examination and to any further examination procedures that the doctor/practitioner deems necessary.

I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

In the interest of total patient care, I give my permission for the providers of CAP Wellness Center to communicate with each other regarding my treatment and care.

I also give my permission for the providers of CAP Wellness Center to communicate with the providers at CAP Women's Health.

Patient Signature: _____

Patient Print Name: _____ Date: _____