

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History

Name (Last, First, Middle): _____ Date: _____

Age at which menses began _____

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How _____

Are your periods painful? Yes No

Date of last Pap smear _____

How many days does the pain last? _____

Have you ever been diagnosed with uterine fibroids or polyps?

How many days do you normally bleed? _____

Yes No

How heavy is the bleeding? Light Normal Heavy

Have you ever been diagnosed with endometriosis? Yes No

What color is the blood? Light red Red Dark red

Have you ever been diagnosed with pelvic adhesions?

Purple Brown Black

Yes No

Is there clotting? Yes No

Have you ever been diagnosed with any pelvic abnormalities?

Do you have premenstrual tension? Yes No

Yes No

Does your face break out before or during your period? Yes No

Have you ever taken any medications for gynecological conditions other than contraceptives?

Do your breasts become tender premenstrual? Yes No

Do you bleed or spot between periods? Yes No

Medication Reason How Long

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

Date of last menstrual period _____

Number Years

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization

or conization? Yes No

Have you ever had a venereal disease? Yes No

Have your cycles changed since they began? Yes No

Do you get yeast infections regularly? Yes No

How? _____

Have you ever been diagnosed with a chlamydial infection? Yes No

Do you ovulate on your own? Yes No

Do you have chronic vaginal discharge? Yes No

On what day of your cycle? _____

Do you have any sores on your genitalia? Yes No

Do your breasts get tender at/during ovulation? Yes No

Do your bowel movements become loose at the beginning of your period?

Do you get premenstrual low back pain? Yes No

Yes No

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When _____ How Long? _____

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

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

How long have you been married or living together? _____

Has he had a fertility workup? Yes No

What were the results? _____

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

Have you taken oral contraceptives? Yes No

When _____ How Long? _____

Have you ever had an IUD? Yes No

When _____ How Long? _____

Have you ever taken DeproProvera? Yes No

When _____ How Long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis related to infertility? Yes No

What was it _____

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

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? 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 diethylstilbestrol (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

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

Answer yes or no to each of the following questions. Disregard what the symptoms mean: just note whether you experience them.

DIAGNOSIS	Yes	No
KIDNEY YIN DEFICIENCY (Ki Yi-)		
Do you have lower back weakness, soreness or pain, or knee problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ringing in your ears or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your midcycle fertile cervical mucus scanty or missing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue lack coating? Does it appear shiny or peeled?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS	Yes	No
KIDNEY YANG DEFICIENCY (Ki Yan-)		
Do you have lower back pain premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early in the morning because you have to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine diluted and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel cold cramps during your period that respond to a heating pad?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue pale, moist, and swollen?	<input type="checkbox"/>	<input type="checkbox"/>

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

DIAGNOSIS

Yes No

SPLEEN QI DEFICIENCY (Sp-)

Are you often fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse, or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation or menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period comes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look swollen, with teeth marks on the side?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

DIAGNOSIS

Yes No

BLOOD DEFICIENCY (BI-) (not necessarily equated with anemia)

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

DIAGNOSIS

Yes No

BLOOD STASIS (BI X) (often associated with blood deficiency symptoms: see BI-)

- Is your menstrual flow ever brown or black in color? Yes No
- Do you feel midcycle pain around your ovaries? Yes No
- Do you have painful, unmovable breast lumps? Yes No
- Do you experience periodic numbness of your hands and feet (especially at night)? Yes No
- Do you have varicose or spider veins? Yes No
- Do you have red hemangiomas (cherry-red spots) on your skin? Yes No
- Does your complexion appear dark and “sooty”? Yes No
- Do you have chronic hemorrhoids? Yes No
- Does your menstrual blood contain clots? Yes No
- Have you been diagnosed with endometriosis or uterine fibroids? Yes No
- Is your lower abdomen tender to palpation (resisting touch)? Yes No
- Can you feel any abnormal lumps in your lower abdomen? Yes No
- Do you have piercing or stabbing menstrual cramps? Yes No
- Does your tongue look dark? Yes No
- Do you have dark spots on your tongue? Yes No
- Are the veins beneath your tongue twisty and tortuous? Yes No
- Do you have dark spots in your eyes? Yes No
- Have you been diagnosed with any vascular abnormality or blood clotting disorder? Yes No

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

DIAGNOSIS

Yes No

LIVER QI STAGNATION (Lv Qi X)

- Are you prone to emotional depression? Yes No
- Are you prone to anger and/or rage? Yes No
- Do you become irritable premenstrually? Yes No
- Do you feel bloated or irritable around ovulation? Yes No
- Does it feel as if your ovulation lasts longer than it should? Yes No
- Are your breasts sensitive/sore at ovulation? Yes No
- Do you experience nipple pain or discharge from your nipples? Yes No
- Do you have a lot of premenstrual breast distention or pain? Yes No
- Have you been diagnosed with elevated prolactin levels? Yes No
- Do you become bloated premenstrually? Yes No
- Are your pupils usually dilated and large? Yes No
- Do you have difficulty falling asleep at night? Yes No
- Do you experience heartburn or wake up with a bitter taste in your mouth? Yes No
- Are your menses painful? Yes No
- Do you feel your menstrual cramps in the external genital area? Yes No
- Os the menstrual blood thick and dark, or purplish in color? Yes No
- Is your tongue dark or purplish in color? Yes No

DIAGNOSIS

Yes No

HEART DEFICIENCY (Ht-) (often associated with heat)

- Do you wake up early in the morning and have trouble getting back to sleep? Yes No
- Do you have heart palpitations, especially when anxious? Yes No
- Do you have nightmares? Yes No
- Do you seem low in spirit or lacking in vitality? Yes No
- Are you prone to agitation or extreme restlessness? Yes No
- Do you fidget? Yes No
- Is the tip of your tongue red? Yes No
- Is there a crack in the center of your tongue that extends to the tip? Yes No
- Do you sweat excessively, especially on your chest? Yes No

Dr. Julie B. Hilbert, DC Inc.

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069

513-777-9428 fax 513-777-3628

www.WestChesterAcuChiro.com / WestChesterAcuChiro@yahoo.com

Women’s Fertility History *continued*

DIAGNOSIS

Yes No

EXCESS HEAT (^H)

- Is your pulse rate rapid? Yes No
- Are your mouth and throat usually dry? Yes No
- Are you thirsty for cold drinks most of the time? Yes No
- Do you often feel warmer than those around you? Yes No
- Do you wake up sweating or having hot flashes? Yes No
- Do you break out with red acne (especially premenstrually)? Yes No
- Do you have a short menstrual cycle? Yes No
- Do you have vaginal irritation or rashes? Yes No

DIAGNOSIS

Yes No

DAMPNESS (D)

- Do you feel tired and sluggish after a meal? Yes No
- Do you have fibrocystic breasts? Yes No
- Do you have cystic or pustular acne? Yes No
- Do you have urgent, bright, or foul-smelling stools? Yes No
- Does your menstrual blood contain stringy tissue or mucus? Yes No
- Are you prone to yeast infections and vaginal itching? Yes No
- Do your joints ache, especially with movement? Yes No
- Are you overweight? Yes No
- Do you have a wet, slimy tongue? Yes No

DIAGNOSIS

Yes No

DAMP HEAT (DH)

- Do you have signs of heat and/or dampness as indicated above? Yes No
- Do you have foul-smelling, yellow, or greenish vaginal discharge? Yes No
- Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? Yes No

DIAGNOSIS

Yes No

COLD UTERUS (CW)

- Do you fit the Kidney Yang deficiency (Ki Yan-) category (see page 3)? Yes No
- Do you fall into the Blood stasis pattern? Yes No
- Does your lower abdomen feel cooler to the touch than the rest of your trunk? Yes No