

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? 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 DepoProvera? Yes No

When _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating 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

COMMENTS/NOTES

Huffman Wellness

Women's Fertility History

ACUPUNCTURE & HERBAL CLINIC

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NAME (LAST, FIRST, MIDDLE)

DATE

Answer yes or no to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third yes responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent yes answers for more than one diagnostic category. Note the abbreviation(s) for your category or categories, then find pertinent treatment principles marked throughout the rest of the book.

DIAGNOSIS

KIDNEY YIN DEFICIENCY (Ki Yi-)

Do you have lower back weakness, soreness, or pain, or knee problems?

Yes No

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?

Does your tongue lack coating? Does it appear shiny or peeled?

DIAGNOSIS

KIDNEY YANG DEFICIENCY (Ki Yan-)

Do you have lower back pain premenstrually?

Yes No

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?

	Yes	No
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"/>

DIAGNOSIS

SPLEEN QI DEFICIENCY (Sp-)

	Yes	No
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"/>

	Yes	No
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS

LIVER QI STAGNATION (Lv Qi X)

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

DIAGNOSIS

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

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

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 have 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? 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

	Yes	No
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 sides?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS

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

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

DIAGNOSIS

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

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