

Fortune Fertility & Acupuncture Center

2007 Village Run Rd., Wexford, PA 15090

www.FortuneFertility.com

(724) 799-8393

	Yes	No	Don't Know
Do you have lower back soreness, or knee problems? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ear ringing or dizziness? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair gray prematurely? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your midcycle fertile cervical mucus scanty or missing? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hot flashes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lower back pain premenstrually? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your sexual desire low? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early in the morning to urinate? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine diluted and/or profuse? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Do you often have fatigue? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lower energy after a meal? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cold hands and feet? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or grogginess in the head? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Is your menstrual blood thin, watery, profuse, or pinkish in color? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation or menstruation? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

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Have you ever been diagnosed with uterine prolapse? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses scanty and/or late? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing hairs on your head (not in patches, but all over)? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Is your menstrual flow ever brown or black in color? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel midcycle pain around your ovaries? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Do you have varicose or spider veins? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender to palpation (resisting touch)? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abdominal lumps in your lower abdomen? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to emotional depression? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated or irritable around ovulation? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distension or pain? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated premenstrually? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night? -----	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Are your menses painful? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genital area? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark, or purplish in color? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No	Don't Know
Do you wake up early in the morning and trouble getting back to sleep? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking in vitality? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your mouth and throat usually dry? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating or have hot flashes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially premenstrually)? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a short menstrual cycle? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired and sluggish after a meal? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or postular acne? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have urgent, bright, or foul-smelling stools? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain stringy tissue or mucus? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infection and vaginal itching? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have foul-smelling, yellow, or greenish vaginal discharge? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your lower abdomen feel cooler to the touch than the rest of your trunk? --	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any symptoms you have that are not listed above.