

Point of Life Acupuncture

Acupuncture and Chinese Herbal Medicine

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Name (Last, First, Middle)	Date
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Age at which menses began _____

Are your periods painful? Yes No

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red

Purple Brown Black

Is there clotting? Yes No

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

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

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

Do you get yeast infections regularly? Yes No

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

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How? _____

Date of last pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

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

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? Yes No

How? _____

Do you ovulate on your own? Yes No

On what day of your cycle? _____

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

Do you get premenstrual low back pain? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

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? _____

Do your bowel movements become loose at the beginning of your period? Yes No

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

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.

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? Yes No
- Does your hair prematurely gray? Yes No
- Do you have vaginal dryness? Yes No
- Is your midcycle fertile cervical mucus scanty or missing? Yes No
- Do you have dark circles around or under your eyes? Yes No
- Do you have night sweats? Yes No
- Are you prone to hot flashes? Yes No
- Would you describe yourself as afraid a lot? Yes No
- Does your tongue lack coating? Does it appear shiny or peeled? Yes No

DIAGNOSIS

KIDNEY YANG DEFICIENCY (Ki Yan-)

- Do you have lower back premenstrually? Yes No
- Is your low back sore or weak? Yes No
- Are your feet cold, especially at night? Yes No
- Are you typically colder than those around you? Yes No
- Is your libido low? Yes No
- Are you often fearful? Yes No
- 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? Yes No
- Do you have early morning loose, urgent stools? Yes No
- Do you have profuse vaginal discharge? Yes No
- Does your menstrual blood tend to be dull in color? Yes No
- Do you feel cold cramps during your period that respond to a heating pad? Yes No

Is your tongue pale, moist, and swollen? Yes No

DIAGNOSIS

SPLEEN QI DEFICIENCY (Sp-)

Are you often fatigued? Yes No

Do you have poor appetite? Yes No

Is your energy lower after a meal? Yes No

Do you feel bloated after eating? Yes No

Do you crave sweets? Yes No

Do you have loose stools, abdominal pain, or digestive problems? Yes No

Are your hands and feet cold? Yes No

Is your nose cold? Yes No

Are you prone to feeling heavy or sluggish? Yes No

Are you prone to feeling heaviness or grogginess in the head? Yes No

Do you bruise easily? Yes No

Do you think you have poor circulation? Yes No

Do you have varicose veins? Yes No

Are you lacking strength in your arms and legs? Yes No

Are you lacking in exercise? Yes No

Are you prone to worry? Yes No

Have you been diagnosed with low blood pressure? Yes No

Do you sweat a lot without exerting yourself? Yes No

Do you feel dizzy or light-headed, or have visual changes when you stand up fast? Yes No

Is your menstruation thin, watery, profuse or pinkish in color? Yes No

Are you more tired around ovulation or menstruation? Yes No

Do you ever spot a few days or more before your period comes? Yes No

Have you ever been diagnosed with uterine prolapse? Yes No

Are your menstrual cramps accompanied by a bearing-down sensation in your uterus? Yes No

Are you often sick, or do you have allergies? Yes No

Have you been diagnosed with hypothyroid or anemia? Yes No

Do you have hemorrhoids or polyps? Yes No

Does your tongue look swollen, with teeth marks on the sides? Yes No

Do you have a pale, yellowish complexion? Yes No

DIAGNOSIS

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

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

DIAGNOSIS

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 distension 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
- Is your menstrual blood thick and dark, or purplish in color? Yes No
- Is your tongue dark or purplish in color? Yes No

DIAGNOSIS

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

DIAGNOSIS

EXCESS HEAT (^H)

- Is your pulse rate rapid? Yes No
- Is 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

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

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

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