

## Chinese Fertility Diagnosis Questionnaire

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.

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
<b>KIDNEY YIN DEFICIENCY (Ki Yi-)</b>		
Do you have lower back weakness, soreness, or pain, or knee problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any gray hair?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mid cycle 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 and/or hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early or late ovulation (i.e., not on day 14-16)?	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as fearful?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth or eyes usually dry?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up in the middle of the night or have any sleep problems?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue lack coating?* Does it appear shiny or peeled? (Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>
 <b>KIDNEY YANG DEFICIENCY (Ki Yan-)</b>		
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"/>
Is 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 clear 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 any vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be not bright 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"/>
Have you been diagnosed with hypothyroidism?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue pale, moist, and swollen?* (Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>
 <b>LIVER QI STAGNATION (Lv Qi X)</b>		
Are you prone to depression, anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrual?	<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 cycle lasts longer than 28-30 days?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distention or pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated premenstrual?	<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"/>
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?* (Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>
 <b>BLOOD STASIS (BI X)</b>		
Is your menstrual flow ever brown or dark in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel mid cycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Yes</b>	<b>No</b>
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 think you have poor circulation?	<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"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<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?*(Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>
Are the veins beneath your tongue twisty and tortuous?*(Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>

#### **SPLEEN QI DEFICIENCY (Sp-)**

Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated or tired 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"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling tired, heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you not exercise because you are too tired?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry or over-thinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<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 menstrual blood thin, watery, profuse, or pinkish in color?	<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"/>
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 food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look swollen, with teeth marks on the sides?*(Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>

#### **BLOOD DEFICIENCY (Bl-)**

Are your menses scanty and/or late?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin and/or chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle, thin, dry, or falling out all over?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?*(By Provider)	<input type="checkbox"/>	<input type="checkbox"/>
Are your lips, the inner side of your lower eyelids, or tongue pale in color?*(By Provider)	<input type="checkbox"/>	<input type="checkbox"/>

#### **HEART DEFICIENCY (Ht-)**

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 lacking in vitality or enthusiasm?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<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?*(By Provider)	<input type="checkbox"/>	<input type="checkbox"/>

#### **DAMPNESS (D)**

Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have foul-smelling stools?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a wet, slimy tongue?*(Determined by provider)	<input type="checkbox"/>	<input type="checkbox"/>