

# Fertility History Form

Today's date:																	
Name:																	
Date last menses (period) began:	At what age did you have your first menstruation?																
Is your menstrual cycle <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Do you ovulate on your own? <input type="checkbox"/> Yes <input type="checkbox"/> No																
How long is your typical cycle? (i.e. 24-30 days): _____ days	Do you experience pain around ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No																
How many days do you bleed in total? _____ days	Do your breasts get tender around ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No																
Check what describes your flow and the consistency and color of the blood:	Do you chart your cycle? <input type="checkbox"/> No <input type="checkbox"/> BBT <input type="checkbox"/> Ovulation sticks <input type="checkbox"/> Saliva																
<table border="0"> <tr> <td>Flow</td> <td>Consistency</td> <td colspan="2">Color</td> </tr> <tr> <td><input type="checkbox"/> Light</td> <td><input type="checkbox"/> Watery</td> <td><input type="checkbox"/> Dark red</td> <td><input type="checkbox"/> Brown</td> </tr> <tr> <td><input type="checkbox"/> Moderate</td> <td><input type="checkbox"/> Moderate</td> <td><input type="checkbox"/> Red</td> <td><input type="checkbox"/> Purple</td> </tr> <tr> <td><input type="checkbox"/> Heavy</td> <td><input type="checkbox"/> Thick</td> <td><input type="checkbox"/> Brownish red</td> <td><input type="checkbox"/> Pink</td> </tr> </table>	Flow	Consistency	Color		<input type="checkbox"/> Light	<input type="checkbox"/> Watery	<input type="checkbox"/> Dark red	<input type="checkbox"/> Brown	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Heavy	<input type="checkbox"/> Thick	<input type="checkbox"/> Brownish red	<input type="checkbox"/> Pink	Do you notice stretchy, slippery, clear, egg white-like mucous around ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Flow	Consistency	Color															
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<input type="checkbox"/> Heavy	<input type="checkbox"/> Thick	<input type="checkbox"/> Brownish red	<input type="checkbox"/> Pink														
At which point in the cycle does your blood contain clots? <input type="checkbox"/> Never	<input type="checkbox"/> Start <input type="checkbox"/> Midpoint <input type="checkbox"/> End																
Do you experience menstrual pain? <input type="checkbox"/> No	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> Intermittent																
Is the pain: <input type="checkbox"/> Stabbing <input type="checkbox"/> Cramping <input type="checkbox"/> Dull Ache <input type="checkbox"/> Heavy	<input type="checkbox"/> On/Off What relieves the pain?:																
Do you experience any of these PMS symptoms?	<input type="checkbox"/> Breast tenderness <input type="checkbox"/> Cramps <input type="checkbox"/> Nausea <input type="checkbox"/> Fatigue <input type="checkbox"/> Acne <input type="checkbox"/> Moodiness <input type="checkbox"/> Headaches <input type="checkbox"/> Bloating <input type="checkbox"/> Change in bowel <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Night sweats <input type="checkbox"/> Other:																
Have you had any miscarriages or stillborn births? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many times have you been pregnant?																
If yes, how many and number of weeks pregnant:	How many times have you given birth?																
	Age(s) of child(ren):																
How many times have you had a D&C performed?	<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> C-Section <input type="checkbox"/> Premature ____ weeks																
How many abortions have you had? In what year(s)?	Other problems during pregnancies:																
	Have you had any tubal operations? <input type="checkbox"/> Yes <input type="checkbox"/> No																
	Have you taken medication to help you ovulate? <input type="checkbox"/> Yes <input type="checkbox"/> No																
	What kind? _____ For how many cycles?																
Which forms of chemical contraception have you used, for how long and when did you stop? (time used/approx. date ended)	Have you had your uterine/fallopian tubes evaluated medically? <input type="checkbox"/> Yes <input type="checkbox"/> No																
<input type="checkbox"/> Oral _____/_____ <input type="checkbox"/> Depo-Provera _____/_____	If yes, what were the results?																
<input type="checkbox"/> IUD _____/_____ <input type="checkbox"/> Other:																	

# FERTILITY HISTORY

Patient last name:

Do you have a partner with whom you have been trying to conceive? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is his / her name?	
How long have you been married or living together?		Is he / she supportive of your wish to conceive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your relationship:		How long have you been trying to conceive?	
Have either of you had a Western medical diagnosis relating to fertility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?			
If yes, please describe the diagnosis for her:		For him:	
Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Clinic	Month / Year	Type of treatment	Results
Are you using donor sperm? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How would you rate your level of sexual desire: <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High		Has this level changed? <input type="checkbox"/> Decreased <input type="checkbox"/> Increased <input type="checkbox"/> Unchanged	
What is your orgasm frequency/ intensity? <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High		Has this level changed? <input type="checkbox"/> Decreased <input type="checkbox"/> Increased <input type="checkbox"/> Unchanged	
Do you use vaginal lubricants? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you been exposed to or received chemotherapy/radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you ever experienced an emotional, spiritual, or physical incident from which you feel you have never recovered your previous level of health? Please discuss:			
Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. On your journey toward parenthood, what expectations do you have of our practice? Please provide the wellness goals you wish to attain here:			
Have you had any hormone lab tests performed? Please indicate the results:			
FSH <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low	Prolactin <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low		
Estrogen, E2 <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low	Thyroid <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low		
Progesterone <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low	Vitamin D <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low		
Testosterone <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low	DHEA <input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Low		
Have you ever been diagnosed with:		Gynecological history:	
Pelvic Inflammatory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your last pap smear _____		
Uterine fibroids <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an abnormal pap smear?		
Polyps <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a cervical biopsy or operation?		
Pelvic adhesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you get yeast infections frequently? > 4x/year		
Prolapsed uterus <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you get bladder infections or UTIs frequently?		
Endometriosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you experience vaginal discharge?		
PCOS (polycystic ovarian syndrome) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe color, consistency and odor:		
Unique shape of uterus <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Pink <input type="checkbox"/> Red		
STD <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Thin/Watery <input type="checkbox"/> Thick <input type="checkbox"/> Sticky		
If yes, please list STDs:	Odor:		