Fertility Patients Only – Confidential

Name or RE or OBGYN: _____

Age of when you started menstruating: _____

History of menstrual cycle: heavy painful cramps irregular clots PMS headaches other _____

How long have you been trying to conceive? _____

Have you had fertility treatments? Yes No

If yes, when and where?

Have you taken medication to help you ovulate? Yes No

By whom? _____

What types? _____ When? _____

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

How is your sexual energy? Low Normal High Do you douche regularly? Yes No

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

What do you do for exercise? _____

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?

Have you been exposed to any known environmental toxins or hormones? Yes No

Do you have any sores on your genitalia? 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

Do you have PMS ? Yes No Do you bleed or spot between periods? Yes No

Do your breasts become tender premenstrually? Yes No

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

How many times 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 been diagnosed with endometriosis? Yes No

Are you presently taking steroids? Yes No

Have you taken oral contraceptives? Yes No Have you ever had an IUD? Yes No

When? _____What kind? _____ When? _____

Have you used any patches, shots or any other contraceptive? Yes No
If yes, what kind? _____ When? _____

Have you been on Clomid? Yes No If yes, when? _____
Results? _____

What forms of assisted reproductive therapies have you tried?

IUI: When _____ Results: _____
How many attempts: _____

IVF: When _____ Results: _____
How many attempts: _____

- # of eggs retrieved: _____ Was ICSI used: Yes No
- # of eggs fertilized: _____
- # of embryos transferred: _____

Periods are: Short (< 28 days) ____ Long (28+ days) ____ Varied ____ Regular ____

How many days do you bleed during your menses cycle? _____

What is the color of your blood? Red Dark Red Pink Brown Watery

What is the flow of your cycle during: (circle one for each stage)

Beginning:	Spotty	Light	Medium	Heavy
Middle:	Spotty	Light	Medium	Heavy
End:	Spotty	Light	Medium	Heavy

Do you experience clots? Please describe them: _____

Have you had your thyroid checked: Yes No Results: _____

Have you ever been pregnant before: Yes No When: _____ How many? _____

Number of: Births _____ Abortions _____ Miscarriages _____

What are your most recent Day 3 hormones levels for the following:

FSH_____ LH_____ Estradiol:_____ TSH_____ Prolactin:_____

What are your most recent 6 DPO (days past ovulation) progesterone levels? _____

Have you had further thyroid tests? If so, what are the following levels?

Free T3_____ Free T4_____ Anti-TPO_____ Anti-TG_____

What are your partner's semen analysis results: Age_____

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

Men's Health History **CONFIDENTIAL**

How long have you and your partner been trying to conceive? _____

How is your sexual energy? Low Normal High

Do you have undescended testes? Yes No

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you had a vasectomy reversed? Yes No

Have you experienced difficulty maintaining an erection? Yes No

Have you experienced difficulty ejaculating? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Do you smoke? Yes No Do you eat soy products? Yes No

Do you eat lots of processed snack foods? Yes No

Have you experienced penile discharge? Yes No

Have you had a fertility workup? Yes No

Do you regularly experience nocturnal emissions? Yes No

If yes, what was your sperm count?
Below normal Normal Number_____

What was the sperm motility?
Below normal Normal Specifics_____

What was your sperm morphology?
Below normal Normal Specifics_____

Are you taking any prescription medications? Yes No

If so, what are they? _____

Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

_____