Fertility History Form

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Today's date:

Name:

Date last menses (period) began:

At what age did you have your first menstruation?

Is your menstrual cycle ☐ Regular ☐ Irregular

Do you ovulate on your own? ☐ Yes ☐ No

How long is your typical cycle? (i.e. 24-30 days): days

Do you experience pain around ovulation? ☐ Yes ☐ No

How many days do you bleed in total? days

Do your breasts get tender around ovulation? ☐ Yes ☐ No

Check what describes your flow and the consistency and color of the blood:

Flow	Consistency	Color	
☐ Light	☐ Watery	☐ Dark red	☐ Brown
☐ Moderate	☐ Moderate	☐ Red	☐ Purple
☐ Heavy	☐ Thick	☐ Brownish red	☐ Pink

Do you chart your cycle? ☐ No ☐ BBT ☐ Ovulation sticks ☐ Saliva

Do you notice stretchy, slippery, clear, egg white-like mucous around ovulation? ☐ Yes ☐ No

At which point in the cycle does your blood contain clots? ☐ Never ☐ Start ☐ Midpoint ☐ End

Do you experience menstrual pain? ☐ No ☐ Before ☐ During ☐ After ☐ Intermittent

Is the pain: ☐ Stabbing ☐ Cramping ☐ Dull Ache ☐ Heavy ☐ On/Off What relieves the pain?:

Do you experience any of these PMS symptoms? ☐ Breast tenderness ☐ Cramps ☐ Nausea ☐ Fatigue ☐ Acne ☐ Moodiness
☐ Headaches ☐ Bloating ☐ Change in bowel
☐ Sleep disturbances ☐ Night sweats ☐ Other:

Have you had any miscarriages or stillborn births? ☐ Yes ☐ 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?

☐ Vaginal Delivery ☐ C-Section ☐ Premature _____ weeks

How many abortions have you had? In what year(s)?

Other problems during pregnancies:

Have you had any tubal operations? ☐ Yes ☐ No

Have you taken medication to help you ovulate? ☐ Yes ☐ 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)

☐ Oral _____/_____ ☐ Depo-Provera _____/_____
☐ IUD _____/_____ ☐ Other:

Have you had your uterine/fallopian tubes evaluated medically? ☐ Yes ☐ No

If yes, what were the results?

FERTILITY HISTORY

Patient last name:

Do you have a partner with whom you have been trying to conceive? ☐ Yes ☐ No	What is his / her name?
How long have you been married or living together?	Is he / she supportive of your wish to conceive? ☐ Yes ☐ No
Describe your relationship:	How long have you been trying to conceive?
Have either of you had a Western medical diagnosis relating to fertility? ☐ Yes ☐ No If yes, when?	
If yes, please describe the diagnosis for her:	For him:

Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) ☐ Yes ☐ No

Clinic	Month / Year	Type of treatment	Results

Are you using donor sperm? ☐ Yes ☐ No

How would you rate your level of sexual desire: ☐ Low ☐ Average ☐ High	Has this level changed? ☐ Decreased ☐ Increased ☐ Unchanged
What is your orgasm frequency/ intensity? ☐ Low ☐ Average ☐ High	Has this level changed? ☐ Decreased ☐ Increased ☐ Unchanged
Do you use vaginal lubricants? ☐ Yes ☐ No	Have you been exposed to or received chemotherapy/radiation? ☐ Yes ☐ 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	☐ High	☐ Normal	☐ Low	Prolactin	☐ High	☐ Normal	☐ Low
Estrogen, E2	☐ High	☐ Normal	☐ Low	Thyroid	☐ High	☐ Normal	☐ Low
Progesterone	☐ High	☐ Normal	☐ Low	Vitamin D	☐ High	☐ Normal	☐ Low
Testosterone	☐ High	☐ Normal	☐ Low	DHEA	☐ High	☐ Normal	☐ Low

Have you ever been diagnosed with:		
Pelvic Inflammatory Disease	☐ Yes	☐ No
Uterine fibroids	☐ Yes	☐ No
Polyps	☐ Yes	☐ No
Pelvic adhesions	☐ Yes	☐ No
Prolapsed uterus	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
PCOS (polycystic ovarian syndrome)	☐ Yes	☐ No
Unique shape of uterus	☐ Yes	☐ No
STD If yes, please list STDs:	☐ Yes	☐ No

Gynecological history:

Date of your last pap smear _____

Have you ever had an abnormal pap smear?

Have you ever had a cervical biopsy or operation?

Do you get yeast infections frequently? > 4x/year

Do you get bladder infections or UTIs frequently?

Do you experience vaginal discharge?

If yes, please describe color, consistency and odor:

☐ White ☐ Yellow ☐ Green ☐ Pink ☐ Red

☐ Thin/Watery ☐ Thick ☐ Sticky

Odor: