Fertility Intake

NAME _________________________________ AGE___ DATE __________

Partner's name ________________________ AGE___

Date of last menstrual period ________
Number of pregnancies _________
Dates (year)______________
Number of children?_______

Number of abortions? ______
Number of miscarriages? ________
Number of D and C's? ______
Date of last PAP? _____

GYNECOLOGICAL HISTORY ***Check if you have had any of the following.***

____ Abnormal PAP?
____ Cervical biopsy, cauterization or conization?
____ Venereal disease?
____ Recurrent yeast infections?
____ Chronic vaginal discharge?
____ Uterine fibroids or polyps?
____ Endometriosis

____ Pelvis adhesions?
____ Pelvic abnormalities?
____ Excessive facial hair?
____ Excessively oily skin?
____ Discharge from your nipples?
____ Hair loss?

GENERAL

Is your sex drive low / normal / high?
Do you douche regularly? Y N
Do you use vaginal lubricants?________
Do you exercise regularly? _______

Are you more than 20% above your ideal body weight? Y N
Are you more than 20% below your ideal body weight? Y N
Do you have high stress levels?______

MENSES

How long is your cycle from first day of bleeding to the next cycle's first day of bleeding? __________

Do you spot or stain before your period?___ How many days before?_______

Cramping and pain with your period? Y N Before / during / after How many days does the pain last?___

____Signature___________________Date

Is the bleeding light / medium / heavy? Is there clotting or clumps? ____

What color is the blood? Light red / red / dark red / purple / brown / black

PMS

Do you get PMS? Y N Breast tenderness before period/ at ovulation? Y N
Low back pain before your period? Y N Looser bowel movements before your period? Y N

OVULATION

Has your cycle changed recently? ______ How? ________________________________
Do you ovulate on your own? Y N What day of your cycle?________
Do you track your temperature? Y N
Do you notice fertile cervical mucus (slippery and profuse) at ovulation? Y N ____________
Do you have an increased libido at ovulation?_______
Do you note your cervical position? Y N _____________

FERTILITY

Have you had fertility treatments? Y N If yes, where and when_____________________________ What types?____

Have you been given a diagnosis relating to fertility? Y N What was it?___________________________

How long have you been trying to conceive? __________

Have you ever taken medication to help you ovulate? Y N What?____________________________
When?___________ How long?________ Results?_______________________________________

Have you fallopian tubes been medically evaluated?_____ Results?___________________________

Have you had any tubal operations? Y N Which? ____________________

Have you had any hormone lab test performed? Y N What were the results?____________________

CONTRACEPTION

Have you taken oral contraceptives? Y N How long?_________
Have you taken Depro Provera? Y N How long? _________
Have you had an IUD? ______ How long? _________

ENVIRONMENT

Have you been exposed to environmental toxins? Y N What? ____________________

____Signature____________________Date

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?   Y   N

PARTNER

Do you have a partner with whom you are trying to conceive? Y   N
Is your partner supportive of your wish to conceive?   Y   N   ________________________
Has your partner/ your sperm donor had a fertility workup?   Y   N   What were the results?__________
Has your partner/ donor had children previously?   Y   N

____Signature____________________Date