Name: _____ Birth Date: _____/_____/_____

Please bring this form with you in addition to the general female intake form.

Fertility History

How long have you been trying to conceive? _____
Is there a history of infertility in your family? □ Yes □ No
Please describe: _____

Have you had fertility treatments? □ Yes □ No
If yes, when and where _____
What types? _____

Have you taken medication to help you ovulate? □ Yes □ No
When? _____ For how long? _____

Have your fallopian tubes been evaluated medically? □ Yes □ No
Results:_____
Have you had any tubal operations? □ Yes □ No If yes, please describe: _____
Have you been told you have a tipped uterus? □ Yes □ No
Have you been told you have a uterine septum, arcuate uterus or other uterine abnormalities? □ Yes □ No
If yes, please describe: _____
Have you been diagnosed with PCOS (Poly Cystic Ovary Syndrome)? □ Yes □ No
If yes, when? _____ Please describe any treatments: _____
Have you been diagnosed with endometriosis? □ Yes □ No If yes, when? _____
Have you been diagnosed with uterine fibroids or polyps? □ Yes □ No
Have you had any hormone lab tests performed? □ Yes □ No If yes, please bring a copy with you to your first appointment.

Is your partner supportive of your wish to conceive? □ Yes □ No
If Male, has he had a fertility work up? □ Yes □ No
Results: _____

Have you taken oral contraceptives? □ Yes □ No
Type: _____ When? _____ How long?_____
Have you ever had an IUD? □ Yes □ No
Type: _____ When? _____ How long? _____
Have you ever taken Depo-Provera? □ Yes □ No
When? _____ How long? _____
Have you had a diagnosis relating to infertility? □ Yes □ No
What was the diagnosis? _____

How is your sexual energy? □ Low □ Normal □ High
Are you experiencing any sexual problems? □ Yes □ No If yes, please describe: _____
Does your partner experience any sexual dysfunction? □ Yes □ No
If yes, please describe: _____
Do you douche regularly? □ Yes □ No
If yes, with what? _____
Do you use vaginal lubricants? □ Yes □ No
Do you have a stressful occupation? □ Yes □ No
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) while pregnant with you? □ Yes □ No
Have you been exposed to any known environmental toxins or hormones? □ Yes □ No
Are you presently taking steroids? □ Yes □ No
Do you fill out a Basal Body Temperature (BBT) chart? □ Yes □ No If yes, please bring it with you to your first appointment.

Is there anything else about you or your fertility history you feel we should know? _____
_____