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Date \_\_\_\_\_

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Confidential intake of Women's Fertility History

(Feel free to skip any questions that do not pertain to your partner, if you are using a donor)

Name \_\_\_\_\_ Best number to reach you \_\_\_\_\_

Current Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Current Medications, Herbs or Supplements \_\_\_\_\_

Are you allergic to any medications? Yes No

Are you currently seeing a Reproductive Endocrinologist? Yes No

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Are we authorized to contact your RE with any questions we may have? Yes No

Will you be trying to get pregnant naturally, with an IUI or IVF procedure? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever been pregnant? Yes No When? \_\_\_\_\_

What was the result of those pregnancies? \_\_\_\_\_

How long have you been trying to have a child? \_\_\_\_\_

Have you gone through an IUI or IVF? Yes No What was the result? \_\_\_\_\_

Are you ovulating? \_\_\_\_\_ If so, how do you know? \_\_\_\_\_

What day do you typically ovulate? \_\_\_\_\_

Do you have cervical mucus (egg white)? Yes No Do you have pain with ovulation? Yes No

Are you tracking your temperatures with BBT? Yes No (If you have, please bring these with you.)

Have you ever been on the birth control pill, when and how long? \_\_\_\_\_

Have you had an HSG? Yes No Have you been diagnosed with any pelvis abnormalities? Yes No

Do you experience pain with deep penetration during intercourse? Yes No

Are your breasts healthy? Yes No Do you have any secretions from your nipples? Yes No

Please fill in the following from the last 6 months (and bring any blood tests you have with you):

FSH \_\_\_\_\_ LH \_\_\_\_\_

Estradiol \_\_\_\_\_ Progesterone (7DPO) \_\_\_\_\_

Have you had or have any of the following (circle what applies):

Endometriosis Yes No Past Current \_\_\_\_\_  
Uterine Fibroids Yes No Past Current \_\_\_\_\_  
Ovarian Cysts Yes No Past Current \_\_\_\_\_  
Polyps Yes No Past Current \_\_\_\_\_  
HPV Yes No Past Current \_\_\_\_\_  
STD's Yes No Past Current \_\_\_\_\_  
Yeast Infections Yes No Past Current \_\_\_\_\_  
PCOS Yes No Past Current \_\_\_\_\_  
Fibrocystic Breast  
Disease Yes No Past Current \_\_\_\_\_  
Abnormal PAP Yes No Past Current \_\_\_\_\_

Check any below that you or a family member have had:

Stroke (before the age of 65) Yes No  
Heart attack (before the age of 65) Yes No  
Thyroid Disorder Yes No  
Rheumatoid arthritis Yes No  
Lupus Yes No

Any other autoimmune or thrombophilic diseases? Explain \_\_\_\_\_

Has there been any blood female in your family that has had trouble conceiving? Yes No

Explain \_\_\_\_\_

Has any blood female in your family had a miscarriage? Yes No \_\_\_\_\_

Do you drink alcohol? Yes No How often? \_\_\_\_\_

Do you smoke cigarettes? Yes No How often? \_\_\_\_\_

Do you drink caffeine? Yes No What kind? \_\_\_\_\_ How much? \_\_\_\_\_

Do you take any recreational drugs? Yes No How often? \_\_\_\_\_

Would you say you eat healthy? Yes No

What is your exercise regimen? \_\_\_\_\_

What is your stress level? (Circle) Very high High Moderate Light None

Has your male partner ever impregnated someone? Yes No When? \_\_\_\_\_ Birth? Yes No

Please fill in the following:

Sperm Volume \_\_\_\_\_ Sperm Morphology \_\_\_\_\_

Sperm Motility \_\_\_\_\_ Sperm Count \_\_\_\_\_

Any DNA testing? Yes No