FEMALE FERTILITY – PATIENT HISTORY

Please fill in to the best of your ability. If you are unsure it is fine to leave blank.
Thank you.

Date_____

Patient Name_____ Date of Birth_____

Ob/Gyn name and location _____

Fertility Center _____

Fertility Doctor _____

Are you preparing for an IVF cycle? Yes / No

Frozen Cycle: Yes / No Donor Cycle: Yes / No Surrogate: Yes / No

Estimated Retrieval Date_____ Estimated Transfer Date_____

Prior IVF History (please provide date, fertility center and outcome of cycle)
1.)_____
2.)_____
3.)_____
4.)_____
5.)_____
6.)_____

Prior IUI History (dates/outcome)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Problematic Diagnosis with date of diagnosis if possible:

FSH / LH_____

Endometriosis _____

Ovaries / PCOS _____

Fibroids _____

Fallopian Tubes _____

Uterine lining _____

Thyroid _____

NK Assay/Immunolgy_____

Blood Clotting Issues ?_____

Partner's Sperm: Mobility_____ Morphology_____ Quantity_____

Other issues of partner affecting fertility_____

Patient History:

How long have you been trying to conceive?_____

Prior pregnancies (dates) _____

Terminated (dates) _____

Miscarriages (dates) _____

Children (date of births) _____

Menstrual History:

Age of first period _____ Prior to fertility treatments, were your cycles regular? Y / N

Interval between periods (day between one period to the next)_____

How many days of flow_____

Color of blood (bright red, dark, etc)_____ Clots_____

Is there spotting before your actual flow? If so, how long does it last and what color is it?

_____

Do you experience PMS symptoms? If so,

what?_____

_____

How close to your period do experience these symptoms?_____

Do you ovulate?_____

How do you know you ovulate?_____

Do you get cervical mucus at ovulation?_____

What day of your cycle typically is ovulation?_____

Other information:
Have you ever had a venereal disease? Please detail_____

Do you get yeast infections often?_____

Do you have herpes or sores on your genitals?_____

Have you taken birth control pills in the past? Please provide dates._____

Do you douche?_____ Do you use lubricants?_____

Do you exercise regularly?_____

If so, what do you like to do for exercise and how often?_____
_____
_____

Do you have a good outlet for stress? If so, what?_____
_____

Do you feel your stress level is high?_____

What medications are you taking?_____
_____
_____
_____

What vitamins or supplements are you taking?_____
_____
_____
_____

Do you eat a well balanced diet? Always Sometimes Occasionally Never

Do you eat breakfast? Always Sometimes Occasionally Never

Do you sleep well?_____ How many hours on average a night?_____

Do you smoke?_____ How often?_____

Do you drink alcohol? _____How often?_____

Do you drink coffee / caffeine drinks? _____ How often?_____

Do you use recreational drugs? _____ What?_____

How often?_____

Your Overall Health: Excellent Good Fair Slightly Poor

Do you have a tendency to feel hot or cold?_____

Any other major health issues or concerns?

_____

_____

_____

For Office Use
Diagnosis
Treatment Principles
Herbs Other Recommendations
Comments