



**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Fertility Information

### Gynecological Exams:

- ❖ Sonogram of your reproductive organs?  Yes  No  
Results? \_\_\_\_\_
- ❖ Cervical Biopsy?  Yes  No  
Results? \_\_\_\_\_
- ❖ Hysterosalpingogram (HSG) – results:  Positive  Negative
- ❖ Hormonal Tests:
  - FSH .....  Normal  High  Low
  - Estrogen, E2 .....  Normal  High  Low
  - Progesterone .....  Normal  High  Low
  - Prolactin .....  Normal  High  Low
  - Thyroid .....  Normal  High  Low
  - Testosterone .....  Normal  High  Low

### Previous Gynecological Surgeries:

- Dilation & Curettage (D&C)
- Laparoscopy (endometriosis / cysts / fibroids)
- Hysteroscopy (results: \_\_\_\_\_)

### Fertility Medications taken within last year:

Date	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Have you ever been diagnosed with:

- STDs.....  Yes  No
- Pelvic Inflammatory Disease.....  Yes  No
- Uterine Fibroids .....  Yes  No
- Polyps.....  Yes  No
- Pelvic Adhesions .....  Yes  No
- Prolapsed Uterus .....  Yes  No
- Abnormal shape of Uterus .....  Yes  No
- Endometriosis. ....  Yes  No
- PCOS .....  Yes  No
- Unique shape of uterus.....  Yes  No
- Poor Ovarian Reserve.....  Yes  No
- Unexplained Infertility.....  Yes  No

### Oral Contraceptives:

- ❖ Have you taken oral contraceptives? .....  Yes  No  
If yes, for how long? \_\_\_\_\_  
When did you stop? \_\_\_\_\_
- ❖ Have you ever had an IUD? .....  Yes  No  
What type of IUD? \_\_\_\_\_

### Number of: List the dates:

Pregnancies	_____	_____
Ces rean Births	_____	_____
Vaginal Births	_____	_____
Abortions	_____	_____
Miscarriages	_____	_____
Failed IUI's	_____	_____
Failed IVF's	_____	_____
Bladder infections / year	_____	_____
Yeast infections / year	_____	_____

### Spouse Information:

- Spouse's Name: \_\_\_\_\_
- Spouse's Age: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_
- Has your spouse fathered other children? \_\_\_\_\_

### Sperm Analysis

Count:	_____
% normal morphology:	_____
Motility:	_____

### Menstrual Cycle:

- What age did you start your 1<sup>st</sup> period: \_\_\_\_\_
- Menstrual Cycle Length (ex: 26-30 days): \_\_\_\_\_
- How many days do you bleed (do not count spotting)? \_\_\_\_\_

### OVULATION:

- ❖ Do you take medications to help you ovulate? .....  Yes  No  
If yes, what kind? \_\_\_\_\_  
For how many cycles? \_\_\_\_\_
- ❖ Do you chart your cycle? (circle) BBTs / OPKs / Saliva

MENSTRUAL CHART	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>Color (choose one):</b> pale, bright red, dark red, black							
<b>Amount of Flow:</b> how many tampons/pads do you use per day							
<b>Pain/Cramps (choose one):</b> Dull, sharp, none							
<b>Clotting Quantity (choose one):</b> large, few, none							
<b>Clot Size (choose one):</b> Small, medium, large, none							