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Female Fertility Intake Form

Name: _____ **Age:** _____ **Sex:** ____ **Date:** _____

How long have you been trying to conceive? _____

Is there a history of difficulty conceiving or pregnancy loss in your family? _____

Fertility History	**Dates**
☐ Pregnancies	_____
☐ Births	_____
☐ Miscarriages	_____
☐ Abortions	_____
☐ D&C	_____
☐ Terminations	_____
☐ Ectopics	_____
☐ Abnormal Pap	_____

Fertility Treatments & Diagnosis

Have you had any fertility treatments? ☐ Yes ☐ No

Where are you currently being treated (facility) _____ Doctor _____

Diagnosis Related to Fertility? (if any) _____

Your Diagnostics	**Date**	**Your Diagnostics**	**Date**
☐ Elevated FSH	_____	☐ Low Progesterone	_____
☐ Fibroids/Polyps	_____	☐ PID	_____
☐ Endometriosis/Adhesions	_____	☐ Chlamydia	_____
☐ Prem. Ovarian Failure	_____	☐ Herpes	_____
☐ PCOS	_____	☐ Other STDs	_____
☐ Antisperm Antibodies	_____	☐ Herpes	_____

Procedures	**Dates**	**Results**
☐ Laproscopy	_____	_____
☐ HSG (Hysterosalpingogram)	_____	_____
☐ PI (Pulsatility Index)	_____	_____

Lab Tests	Dates	Results
☐ FSH Day 3	_____	_____
☐ Prolactin	_____	_____
☐ HCG	_____	_____
☐ TSH	_____	_____
☐ T3	_____	_____
☐ T4	_____	_____
☐ Free T3	_____	_____
☐ OAR	_____	_____
☐ Others:	_____	_____

Fertility Treatments

Date	Natural, IUI IVF, etc.	Medication?	# Mature eggs /Follicles	Pregnancy Yes/No	If miscarried, what week?

Future ART Plans	Date
☐ IUI with injectables	_____
☐ IUI with oral meds	_____
☐ Clomid	_____
☐ IVF	_____
☐ PDG	_____
☐ Other:	_____

Reproductive Health

At what age was your first menstrual period? _____

When did your last period start? _____ What day of your cycle are you currently on? _____

Do you have regular pap tests? ☐ Yes ☐ No

Do you perform breast self exams? ☐ Yes ☐ No

Are your periods regular? ☐ Yes ☐ No

Are you currently charting your menstrual cycles (BBT charting)? ☐ Yes ☐ No

Are your periods painful? ☐ Yes ☐ No How many days does the pain last? _____

Cramping (mark as appropriate):

When do you feel them? ☐ Before period ☐ After period ☐ During period ☐ Ovulation

Where do you feel them? ☐ Low back ☐ Groin area ☐ Down legs ☐ Abdomen

What is the severity? ☐ Mild ☐ Moderate ☐ Severe

How many days do you normally bleed? _____

Describe menstrual flow? ☐ Scanty ☐ Moderate ☐ Heavy ☐ Watery ☐ Absent ☐ Sticky

What color is the blood? ☐ Light Red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Clot Size: ☐ Dime sized or smaller ☐ Nickel ☐ Larger

PMS Symptoms	**10 Days Before**	**1 Week Before**	**2-3 Days**
Breast tenderness	☐	☐	☐
Depression	☐	☐	☐
Loose Stools	☐	☐	☐
Constipation	☐	☐	☐
Fatigue	☐	☐	☐
Low Back Pain	☐	☐	☐
Facial Break outs	☐	☐	☐
Bloating/water retention	☐	☐	☐
Irritability	☐	☐	☐
Anxiety	☐	☐	☐
Other:	☐	☐	☐

Do you spot or bleed between periods? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Do you have vaginal discharge? ☐ Yes ☐ No When? _____

Color: ☐ Clear ☐ White ☐ Yellow ☐ Brown ☐ Other:

Consistency/Amount: ☐ Profuse ☐ Sticky ☐ Crusty ☐ Wet ☐ Dry

Smell: ☐ None ☐ Strong ☐ Fishy ☐ Sweet ☐ Other:

Do you ovulate on your own? ☐ Yes ☐ No
On what day of your cycle? _____

How is your sexual energy/libido? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes ☐ No
With what? _____

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% below your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation or other significant sources of stress in your life? ☐ 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 any discharge from your nipples? ☐ Yes ☐ No

Do you get pre-menstrual headaches? ☐ Yes☐ No

Do you get headaches after your period? ☐ Yes ☐ No

Do you experience low backache? ☐ Yes ☐ No

Have you been exposed to any environmental toxins or hormones? ☐ Yes ☐ No

Contraception Methods used in the past?	**Dates**
☐Pills	_____
☐Patch (Ortho-Evra)	_____
☐Diaphragm	_____
☐Shot (Depo-Provera)	_____
☐Condoms	_____
☐IUD ☐ Hormonal ☐ Non-Hormonal	_____
☐Vaginal Ring (NuvaRing)	_____
☐Rhythm Method	_____
☐Fertility Awareness Method	_____
☐Other:	_____

Diet/Nutritional Information

How is your appetite?

☐ Normal ☐ Strong ☐ Poor

Please describe your diet (vegetarian, low-carb, vegan, etc.): _____

Typical Daily Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

If you eat any of the following, please check and list how much per week:

☐Candy _____
☐Cookies/Baked Goods _____
☐Chocolate _____
☐White Flour Products _____
☐Soda _____
☐Caffeine/Coffee _____
☐Milk _____

☐Cheese _____
☐Fast Food _____
☐Protein _____
☐Dark Greens _____
☐Fruit _____
☐Alcohol _____

Supplements:

☐Prenatal Brand: _____
☐Fish Oil/DHA Brand: _____
☐Antioxidants Brand: _____
☐Wheat Germ Oil Brand: _____
☐Propolis/Royal Jelly Brand: _____
☐Additional Folic Acid Brand: _____
☐Others:

Partner's History

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No
How long have you been married or living together? _____
Has he had a fertility work up? ☐ Yes ☐ No
If so, what were the results? _____
Is your partner supportive of your wish to conceive? ☐ Yes ☐ No
Does he have any significant health problems? ☐ Yes ☐ No
If so, what? _____

I have completed the above to the best of my ability:

Patient Name _____ Date _____

Signature _____