FEMALE FERTILITY – PATIENT HISTORY

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

Date_____ Patient Name_____
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 / NoSurrogate: Yes / No Estimated Retrieval Date_____ Estimated Transfer Date_____

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

Prior IUI History (dates/outcome)
_____
_____
_____
_____

Date of last period:_____

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'sSperm: 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? If so, please describe symptoms, either emotional or physical:

_____
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?_____

If no, please explain:_____

How many hours on average a night?_____ Do you have nightsweats?_____

How Often?_____ Do you smoke?_____ How often?_____ Do you drink alcohol? _____How often?_____ Do you drink coffee?_____ How often?_____

Do you use recreational drugs? _____ What?_____

How often?_____

Your Overall Health: Excellent Good Fair Poor Do you have a tendency to feel hot or cold?_____ Do you have cold hands and/or feet?_____

Any other major health issues or concerns?

_____

_____

_____