

Name _____ Date _____

Total pregnancies _____ Full term deliveries _____ Premature deliveries _____ Abortions _____ Miscarriages _____

How long have you been trying to conceive? _____

Been medically evaluated? Y / N If Y, what is infertility diagnosis? _____

Hormone labs performed? Y / N If Y, results _____

Fallopian tubes checked? Y / N If Y, results _____

Tubal ligations performed? Y / N If Y, results _____

Your partner been tested? Y / N If Y, results _____

List all therapies (IVF, IUI, Meds, Acupuncture, etc) you **HAVE** done, **ARE** doing, **INTEND** to do & with **WHO**:

Check all that apply

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Excessive hair loss | <input type="checkbox"/> Excessive facial hair | <input type="checkbox"/> Excessively oily skin | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Face breakout at cycle | <input type="checkbox"/> Tender breasts at ovulation | <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> IUD | <input type="checkbox"/> Depo Provera Shot | <input type="checkbox"/> Diaphragm |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Vaginal Lubricants |
| <input type="checkbox"/> Genitalia sores | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Abnormal PAP |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Uterine Polyps | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Cervical Biopsy | <input type="checkbox"/> Cervical Operation(s) | <input type="checkbox"/> Cervical Conization |
| <input type="checkbox"/> PMS (back pain/cramps) | <input type="checkbox"/> PMS (mood swings) | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Spot between Periods |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Bleed after Intercourse | <input type="checkbox"/> Regularly douche |

Are you getting your period? Y / N If N, when was last time? _____ If Y, how many days do you flow for? _____

Cycle Flow: Very Light / Light / Average / Heavy / Varies Typical Color of Blood: Black / Brown / Purple / Red / Light Red

Days between periods? _____ Are you ovulating? Y / N / Not Sure Cycle day you typically ovulate? _____

Age your menses began? _____ (not sure) What day of your cycle are you currently on? _____