Fertility Questions for Women

CONFIDENTIAL

Fertility

Methods/dates of birth control used: ______________________________

Complications? ______________________________

Is fertility an issue? __________ How long have you been trying? __________

Have you received a western diagnosis regarding your fertility? [ ]Yes [ ]No

If yes, please describe: ______________________________

____

How long has this condition persisted? ______________________________

What are you planning to do? [ ]Try naturally [ ]Medicated cycles [ ]IUI [ ]IVF [ ]Other

Estimated date of procedure(s)? ______________________________

What drugs/medications will you be taking in preparation for this procedure, and when do you start?

____

Have you received fertility treatments in the past? [ ]Yes [ ]No

If yes, when and where? __________ By Whom? __________

What type of treatment? ______________________________

Have your fallopian tubes every been evaluated medically? [ ]Yes [ ]No

What were the results? __________ Any Tubal operations? [ ]Yes [ ]No

Have you ever had your FSH level checked on Day 3 of your cycle? [ ]Yes [ ]No Level __________

Have you had any lab tests performed to check your other hormone levels? [ ]Yes [ ]No

What were the results? ______________________________

____

____

Has your partner or spouse had a fertility work-up? [ ]Yes [ ]No

What were the results? ______________________________

____

Is your spouse/partner supportive of your wish to conceive? [ ]Yes [ ]No

Have you received any irregular lab work for your thyroid? [ ]Yes [ ]No

Do you have natural killer cells? [ ]Yes [ ]No

Do you have elevated prolactin? [ ]Yes [ ]No

Have you done LIT or IVIG? [ ]Yes [ ]No When and for how long? __________

Are you presently taking steroids? [ ]Yes [ ]No

Do you ovulate on your own? [ ]Yes [ ]No What day of your cycle? __________

Do you get stretchy cervical mucus at ovulation? [ ]Yes [ ]No [ ]Sometimes

Do you use a BBT graph to chart your cycle? [ ]Yes [ ]No [ ]Sometimes

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(Fertility Continued)...

Have you taken medication to help you ovulate? [ ]Yes [ ]No

When? ________________ For how long? ______________________________

When was your last pap smear? ______________________________

Have you ever had an abnomral pap smear? ______________________________

Have you ever had a cervical biopsy, operation, cauterization, or conization? [ ]Yes [ ]No

History of vaginal infections or sexually transmitted disease? ______________________________

Pain related to intercourse ______________________________

Do you use vaginal lubricants? [ ]Yes [ ]No

How is your sexual energy? [ ]High [ ]Normal [ ]Low

Relationship difficulties around sexuality ______________________________

History of sexual abuse or assault [ ]Yes [ ]No

Do you douche regularly? [ ]Yes [ ]No If yes, with what? ______________________________

Have you ever had pelvic inflammatory disease? [ ]Yes [ ]No

Were you treated for it? [ ]Yes [ ]No How? ______________________________

Do you have uterine fibroids or polyps? [ ]Yes [ ]No

Have you been treated for them? [ ]Yes [ ]No When? ______________________________

Have you been diagnosed with endometriosis? [ ]Yes [ ]No

Have you ever been diagnosed with any pelvic adhesions or abnormalities? [ ]Yes [ ]No

Have you ever taken medication for gynecological conditions other than oral contraceptives? [ ]Yes [ ]No

Please explain: ______________________________

Do you have dark hairs in places they should not be (i.e. face, nipples, etc)? [ ]Yes [ ]No

Do you have excessively oily skin? [ ]Yes [ ]No

Have you experienced excessive loss of head hair? [ ]Yes [ ]No

Have you noticed discharge from your nipples? [ ]Yes [ ]No

Anything else I should know in relation to your fertility?

Other ______________________________

Did your mother or grandmother take DES? [ ]Yes [ ]No

Have you been exposed to any known environmental toxins or hormones? [ ]Yes [ ]No

Family history of ovarian, uterine, cervical or prostate cancer ______________________________

Other relevant fertility history:

Patient Signature

The information provided on this form is true to the best of my knowledge.

Patient Signature______________________________Date______________________