

Fertility Intake – Female (1)

Do you have a single partner with whom you have been trying to conceive? Yes ___ No ___	
What is your partner's name?	How long have you been married or living together?
Do they support your wishes to conceive? Yes ___ No ___	How long have you been trying to conceive?

Have either you or your partner had a western medical diagnosis relating to fertility? Yes ___ No ___	
What was the diagnosis?	Who made the diagnosis?

Have you had any hormone lab tests perform? (i.e. day 3/21)			
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
Other.....	___ Normal	___ High	___ Low

Have you taken medication to help you ovulate? Yes ___ No ___	
If yes, what kind?	For how many cycles?
Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes ___ No ___	
What were the results?	Have you had any tubal operations?

Have you ever undergone reproductive fertility treatments? (IUI, IVF, ICSI, superovulation, etc.) Yes ___ No ___			
Month/Year	Type of Treatment	Clinic	Results

How did you respond to the fertility treatments? Poor ___ Average ___ Good ___
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Are you using a sperm donor? Yes ___ No ___
If yes, why? (circle) Female Partner / Male Partner has semen issues

- How is your sexual desire (mental interest)?..... Low Normal High
- How is your sexual arousal (physically/orgasm)?..... Low Normal High
- Do you use vaginal lubricants?..... Yes No
- Have you been exposed to, or received chemotherapy or radiation?..... Yes No
- Do you have excessive facial/body hair?..... Yes No
- Do you have excessive oily skin?..... Yes No

What is your weight? _____
 What is your height? _____

Fertility Intake – Female (2)

Is your menstrual cycle: Regular ___ Irregular ___	
Date last menses began:	How many days do you bleed in total:
Menstrual cycle length (i.e. 26-30 days):	Age when you had your first menstruation:

Describe your flow: Heavy ___ Light ___ Average ___
Consistency of blood: Watery ___ Thick ___ Average ___
Does your blood contain clots?
At which point during the cycle do the clots occur? Start ___ Mid ___ End ___
Describe the colour of your blood: (circle) Red Dark-Red Brownish-Red Brown Purple Orange-Red Pinkish-Red

Do you experience menstrual pain?
When? Before ___ During ___ (specify days) After ___
What is the character? Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/Off ___
What relieves the pain?

Do you experience pre-menstrual symptoms (PMS)? Please circle all that apply:			
Acne	Bloating	Breast Tenderness	Change in Bowel Habits
Cramps	Fatigue	Headaches	Moodiness
Nausea	Night Sweats	Sleep Disturbance	
Please list any other pre-menstrual symptoms:			

Do you ovulate on your own? Yes ___ No ___	
Do you experience pain around ovulation? Yes ___ No ___	
Do your breasts get tender around ovulation? Yes ___ No ___	
Do you notice stretchy, clear, slippery cervical mucous around ovulation? Yes ___ No ___	
Do you chart your cycle? Yes ___ No ___	How? (circle) BBT Ovulation Sticks Saliva

How many times have you been pregnant? ___ How many times have you given birth? ___ Ages of children: ___ Have you had any miscarriages? Yes ___ No ___ If yes, how many weeks pregnant? ___ In what years? ___	How many times have you had a D&C preformed? ___ How many abortions have you had? ___ In what years? ___ Were there any problems that occurred during these pregnancies? ___
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Have you ever been diagnosed with: STD..... <input type="checkbox"/> Yes <input type="checkbox"/> No Pelvic inflammatory disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No Uterine fibroids..... <input type="checkbox"/> Yes <input type="checkbox"/> No Polyps..... <input type="checkbox"/> Yes <input type="checkbox"/> No Pelvic adhesions..... <input type="checkbox"/> Yes <input type="checkbox"/> No Prolapsed uterus..... <input type="checkbox"/> Yes <input type="checkbox"/> No Unique shape of uterus..... <input type="checkbox"/> Yes <input type="checkbox"/> No Endometriosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No Polycystic ovarian syndrome..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last pap smear: _____ Have you had an abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a cervical biopsy or operation? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get yeast infections? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get regular bladder infections? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list STD's: _____
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Do you experience vaginal discharge? Yes ___ No ___ If yes, please specify: (circle)		
Colour	Consistency	Odor
White Yellow Green Pinkish Red	Watery Thin Thick Sticky	None Foul

Have you taken oral contraceptives? Yes ___ No ___	If yes, for how long? ___	When did you stop? ___
Have you ever had an IUD?.....	Yes ___ No ___	
Have you ever taken Depo-Provera?.....	Yes ___ No ___	