

Patient Name: _____

DOB: _____

Date: _____

Fertility & Menstrual History

Gynecological Exams:

- ❖ Sonogram of your reproductive organs? Yes No
Results? _____
- ❖ Cervical Biopsy? Yes No
Results? _____
- ❖ Hysterosalpingogram (HSG) – results: Positive Negative
- ❖ Hormonal Tests:
 - 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

Previous Gynecological Surgeries:

- Dilation & Curettage (D&C)
- Laparoscopy (endometriosis / cysts / fibroids)
- Hysteroscopy (results: _____)

Fertility Medications taken within last year:

Date	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with:

- STDs..... Yes No
- Pelvic Inflammatory Disease..... Yes No
- Uterine Fibroids Yes No
- Polyps..... Yes No
- Pelvic Adhesions Yes No
- Prolapsed Uterus Yes No
- Abnormal shape of Uterus Yes No
- Endometriosis Yes No
- PCOS Yes No
- Unique shape of uterus..... Yes No
- Poor Ovarian Reserve..... Yes No
- Unexplained Infertility..... Yes No

Oral Contraceptives:

- ❖ Have you take oral contraceptives before? Yes No
If yes, for how long? _____
When did you stop? _____
- ❖ Have you ever had an IUD?..... Yes No
What type of IUD? _____

Number of: List the dates:

Pregnancies		
Cesarean Births		
Vaginal Births		
Abortions		
Miscarriages		
Failed IUI's		
Failed IVF's		
Bladder infections / year		
Yeast infections / year		

Spouse Information:

- Spouse's Name: _____
- Spouse's Age: _____ Spouse's Occupation: _____
- Has your spouse fathered other children? _____

Sperm Analysis

Count:	
% normal morphology:	
Motility:	

Menstrual Cycle:

- What age did you start your 1st period: _____
- Typical Menstrual Cycle length (ex: 26-30 days): _____
- How many days do you typically bleed (do not count spotting)? _____
- Date of last Menses: _____

OVULATION:

- ❖ Do you take medications to help you ovulate? Yes No
If yes, what kind? _____
For how many cycles? _____
- ❖ Do you chart your cycle? (circle) BBTs / OPKs / Saliva

MENSTRUAL INFO	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Color: pale, bright red, dark red, black							
Amount of Flow: how often do you change a pad/tampon? (ie every 2, 4 hours)							
Pain /Cramps: dull , sharp, none							
Size of Blood Clots: small, medium, large, none							
Quantity of Clots: large, few, none							