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| **Women’s Fertility Intake Supplement** | | | |
| **Name**: | | | |
| Are you currently treating with a physician for fertility? YES Have you tried any other alternative treatments for fertility? | *I* NO YES | *I* | NO |
| Name & phone number of your OB/ GYN | | | |
| Name & phone number of your Reproductive Endocrinologist | | | |

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| **Your Gynecological History** | |
| Age your period began | |
| Briefly describe your periods as a teenager | |
| Date of last period | Are your periods regular? YES / NO |
| Days of bleeding | Days between cycles |
| Amount of bleeding: LI GHT- --------------- - MEDIUM---- - ---------- HEAVY | |
| Color of blood: BRIGHT RED *I* PINK *I* PURPLE *I* BROWN *I* BLACK | |
| Clots? YES *I* NO | Spotting between periods? YES *I* NO |
| Do you have premenstrual : [ ] back pain [ ] breast tenderness [ ] irritability [ ] emot ional | |
| Do you have pain with menstruation? YES *I* NO Ml LD----- -----MODERATE----- - ---SEVERE  Is the pain relieved by over the counter medication? YES *I* NO  Does the pain start when bleeding starts? YES *I* NO How long does the pain persist? | |
| Do you know if you are ovulating monthly? YES *I* NO  Do you have pain with ovulation? YES *I* NO What day of your cycle do you ovulate? | |
| Do you have any vaginal discharge? YES *I* NO CLEAR- - --------WH ITE--- -----YELLOW Does it occur with itching or burning? YES *I* NO I s there any odor? YES *I* NO  Do you get yeast infections? YES *I* NO How often? | |
| Do you ever experience pain with sex? YES *I* NO | |
| Have you ever had a sexually transmitted disease/ s? [ ] gonorrhea [ ] herpes [ ] chlamydia [ ] other Was it treated? YES *I* NO Currently treating it? YES *I* NO medication: | |
| Have you ever used birth control? YES *I* NO  The pill? YES *I* NO What type? --------For how long? ----------- When did you stop using it? How long before your periods returned? I UD? YES *I* NO What type? --------------- For how long? ------------------  Any problem s when you had the IUD in?  Other birth control methods: | |
| Please indicate the number of : [ ] Pregnancies [ ] Children [ ] Miscarriages [ ] Abortions  [ ] IVF cycles [ ] IUls | |
| Date of last PAP: Ever have an abnormal PAP? YES *I* NO | |

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| **Surgeries & Procedures (please list dates)** | |
| C-Sections |  |
| Dilation & Curettage ( D & C) |  |
| Hysterosalpingogram ( HSG) |  |
| Hysteroscopy |  |
| Laparoscopy |  |
| Cervical procedure ( biopsy, cautery, conization) |  |
| Tubal operations/ procedures |  |
| Other : |  |

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| **Previous** | | | **<**  **Diagnosis ( please check all that apply)** | |
| [ | ] | advanced maternal age | [ l hyperprolactinemia | [ ] phospholipid antibodies |
| [ | ] | amenorrhea | [ l luteal phase defect | [ ] polycystic ovarian syndrome |
| [ | ] | anovulation | [ ] menorrhagia | (PCOS) |
| [ | ] | cervical stenosis | [ ] ovarian cyst | [ ] polyps |
| [ | ] | elevated FSH | [ ] ovarian hyperstimulation | [ ] premature ovarian failure |
| [ | ] | endometriosis | syndrome | [ ] unexplained infertility |
| [ | ] | fallopian tube blockage | [ ] pelvic adhesions | [ ] uterine fibroids |
| [ | ] | habitual miscarriage | [ ] pelvic inflammatory disease | [ ] other : |
| [ | ] | hostile cervical mucus | ( PI O) |  |

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| **Fertility Histor y** |
| How long have you been trying to get pregnant? |
| List any fertility medication you have taken in the past and are currently taking |
| Did you have a fertility evaluation? YES *I* NO When? |
| Has your partner had a fertility evaluation? YES *I* NO When? |
| Describe your sexual energy LOW- --------------- NORMAL- - - - - - - - - ------ HIGH |
| Do you use vaginal lubricants? YES *I* NO What kind? |
| Do you have facial hair? YES *I* NO I Do you have discharge from your nipples? YES *I* NO |
| Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? |
| Is there a history of infertility in your family (mot her, aunt, sister)? YES *I* NO |
| Have you been exposed to any environmental toxins or hormones? YES *I* NO |