HISTORY OF FERTILITY THERAPY
(Confidential)

General Information

Patient Name: _____ Date: _____
Signature: _____

Name of your fertility doctor/Reproductive Endocrinologist: _____
Name of your fertility clinic: _____
How long have you been trying to get pregnant? _____
Are you currently scheduled to start another IUI or IVF cycle? □ no □ yes Date _____

What cause of infertility was diagnosed? (check all that apply)

- □ High FSH
- □ Uterine Fibroids/Polyps
- □ Endometriosis/Adhesions
- □ Polycystic Ovarian Syndrome (PCOS)
- □ Low Progesterone Level
- □ Unstable Luteal phase
- □ Unexplained infertility
- □ Premature Ovarian Failure (POF)
- □ Ovarian Cysts
- □ Pelvic Infection (PID)
- □ Male Factor
- □ Other _____

Which of the following tests have you or your partner had performed?
Check all that apply and results, if known:

- □ BBT When _____/_____/_____Results _____
- □ Post Coital Test When _____/_____/_____Results _____
- □ Hormonal Assays (FSH,LH,Prolactin,Progesterone,DHEA,Testosterone,Estradiol)
  When _____/_____/_____Results _____
- □ Endometrial Biopsy When _____/_____/_____Results _____
- □ Hysterosalpingogram When _____/_____/_____Results _____
- □ Sonohystogram When _____/_____/_____Results _____
- □ Ultrasound When _____/_____/_____Results _____
- □ Laparoscopy When _____/_____/_____Results _____
- □ Chlamydia culture When _____/_____/_____Results _____
- □ Mycoplasma culture When _____/_____/_____Results _____
- □ Thyroid Test When _____/_____/_____Results _____
- □ Genetic screening When _____/_____/_____Results _____
- □ Chromosomal When _____/_____/_____Results _____
- □ Semen analysis When _____/_____/_____Results _____
- □ Antisperm antibodies When _____/_____/_____Results _____
- □ Varicocele repair When _____/_____/_____Results _____
- □ Testicular biopsy When _____/_____/_____Results _____
- □ Hysteroscopy When _____/_____/_____Results _____
- □ Clomid Challenge When _____/_____/_____Results _____
- □ Tied Fallopian Tubes When _____/_____/_____Results _____
- □ MRI When _____/_____/_____Results _____
- □ Other_____

HISTORY OF FERTILITY THERAPY (cont)

Have you had any of the following? If yes, list how many.

	Number		Number
▪ Pregnancies		▪ Ectopic	
▪ Children		▪ D&C	
▪ Miscarriages		▪ Abnormal Pap	
▪ Abortions		▪ Other	

Please list all pregnancies and fertility treatments (including cancelled cycles)

Date	IUI, IVF, Natural, Other	Medications Used	# Mature eggs / follicles	Pregnancy Yes/No	If miscarriage which week?	Other

Other

Has your husband ever been checked for fertility problems? □ Yes □ No

If yes, results:

Motility □ Good □ Below normal

Morphology □ Good □ Below normal

Count □ Good □ Below normal

Do you get recurrent:

Yeast Infections? □ Yes □ No

UTIs? □ Yes □ No

Other Discharge? □ Yes □ No

Have you ever had:

Chlamydia/STD? □ Yes □ No

Do you ovulate on your own? □ Yes □ No

How can you tell you ovulate? _____

Today is which day of your menstrual cycle? (Day 1 is the first day of a full bleed) ____