Female Fertility Intake Form

Patient Name:_____ Age: _____ Date: _____

How long have you been trying to conceive? _____

Name of the fertility center/group you are working with _____

Name of your GYN/fertility specialist _____

Have you had a western medical diagnosis relating to infertility? If so, what was it? _____

Who made the diagnosis? _____

Current month treatment plan (IVF, IUI, natural, etc.) _____

Date of the last menses:_____ Children's ages: _____ Number of D&Cs: _____

Number of pregnancies: _____ Number of abortions: _____ Date of last PAP: _____

Number of children: _____ Number of miscarriages: _____ Date of last mammogram: _____

Check if you had or have any of the following:

☐Abnormal PAP smear ☐ Frequent bladder infections ☐POF or poor ovarian reserve

☐Cervical biopsy, cauterization, or conization ☐Uterine fibroids or polyps ☐Ovary removal

☐Ectopic or chemical pregnancy ☐Fallopian tube rapture, blockage or ligation ☐Hyperprolactinemia

☐Chlamydial infection ☐Endometriosis ☐ Hyperthyroidism or Hypothyroidism

☐Recurrent yeast infections ☐PID or pelvic adhesions ☐ Fibrocystic breasts

☐Excessive vaginal discharge ☐PCOS ☐Excessive facial hair, oily skin or hair loss

Number of days from one period to the next? (cycle length) _____ Number of days of the flow _____

Do you spot or stain before your period? _____ How many days before? _____

Please check everything that applies

PMS Symptoms	10-14 days prior	1 week prior	2-3 days prior
Breast tenderness			
Depression / Mood swings / Irritability			
Fatigue			
Low back pain			
Abdominal pin			
Headaches			
Skin breakout			
Loose stools / Constipation			
Bloating			
Fluid retention			
Food cravings			

Please check everything that applies

Period Symptoms	Day 1	Day 2	Day 3	Day 4	Day 5	Days 6-7
Low back pain						
Cramps (light / medium / severe)						
Nature of abdominal pain (dull / achy / stabbing)						
Blood flow color (light red / bright red / dark red / purple / brown)						
Average number of tampons/pads you use each day						
Clots (small / medium / large)						

Has your cycle changed recently? If so, how? _____

Do you have a partner with whom you have been trying to conceive? ☐Yes ☐No What is your partner's name? _____

Is your partner supportive of your wish to conceive? ☐Yes ☐No

How long have you been married/living together? _____ How long have you been trying to conceive? _____

Had your partner had a fertility lab tests done? If so, what were the findings? _____

Does your partner have any children? ☐Yes ☐No

Do you ovulate on your own? ☐Yes ☐No What day of your cycle? _____

Have you taken medication to help you ovulate? If so, what kind? _____ For how many cycles? _____

Please mark any of the symptoms you experience around ovulation

☐ Pain

☐ Breast tenderness

☐ Profuse stretchy clear egg white slippery mucus

☐ Increased libido

Are you currently taking any fertility medication? If so, please list: _____

Do you track your basal temperature? If so, what is your average temperature? _____

Please list all fertility treatments you've had (including cancelled cycles)

Date	Method: Natural / IVF / IUI	Medications used	# of mature eggs / follicles	# of eggs fertilized	# of embryos transferred / frozen	Pregnancy (yes / no)	Children	Miscarriage (what week)

Have you had any hormonal lab tests performed? If so, please indicate the findings:

	Normal	High	Low
FSH	☐	☐	☐
AMH	☐	☐	☐
Prolactin	☐	☐	☐
Thyroid	☐	☐	☐
Progesterone	☐	☐	☐
Testosterone	☐	☐	☐

Have your fallopian tubes been medically evaluated? If so, what were the findings? _____

Name and form of birth control (if applicable) _____ How recently? _____

For how long? _____ Why did you stop? _____

Is your sex drive ☐ Low ☐Average ☐High

Do you experience vaginal dryness? ☐Yes ☐No

Are you more than 20% above your ideal weight? ☐Yes ☐No

Are you more than 20% below your ideal weight? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

If so, do you take medication for it? ☐Yes ☐No What medication? _____

Do you have any heart problems? If so, please describe _____

Do you have a history of breast cancer? If so, who in your family has it? _____

How are your stress levels? ☐Low ☐Medium ☐High

What do you do for relaxation? Please describe _____

Do you exercise? Please list the type(s) of exercise and how often _____

Have you been exposed to environmental toxins? ☐Yes ☐No Which one(s)? _____

Have you had any counselling since trying to conceive? ☐Yes ☐No

Any comments you wish to add? _____

_____