Name:________________________________ Date of Birth:___/___ /___ Today's Date: ___ /___ /___

General Information

	Yes	No
Are you now or could you be pregnant?	❑	❑
Date of conception___________		
Do you have a history of miscarriage?	❑	❑
Have you ever been diagnosed with		
Hepatitis?	❑	❑
HIV?	❑	❑
AIDS?	❑	❑
TB?	❑	❑
If so, when?____________		

	Yes	No
Do you have a pacemaker, heart arrhythmia, or other heart condition?	❑	❑
Have you ever had blood-clotting problems or problems with bleeding?	❑	❑
Are you on blood thinning medications?	❑	❑
Do you take aspirin regularly?	❑	❑

How would you describe your overall general health now? *Poor* *Fair* *Good* *Excellent*
How has your health been most of your life? *Poor* *Fair* *Good* *Excellent*

Do you have any chronic health problems or diagnoses, (such as anemia, high cholesterol, high blood pressure, hypoglycemia, gastrointestinal problem, etc.)? Please include date diagnosed and all current and past treatment.

Prescription Medications
Please list any non-fertility prescription medications you are currently taking and what they are for:

Vitamins/Supplements
Please list any vitamins or other supplements you are taking:

Surgical History
Please list all surgeries and approximate age:

Allergies
Specific allergen and reaction:

Major Accidents/Injuries
Please list any major accidents (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

Family Medical History
Please indicate any illness/disorders that have occurred in your immediate family (include parents, siblings, and grandparents)

❑ Diabetes ❑ Cancer ❑ High Blood Pressure ❑ Heart Disease ❑ Stroke

❑ Other_______________________________________

Sleep
Please describe your sleep:

Hours per night ___________

Do you wake most nights? ❐ Yes ❐ No If so, do you wake at the same time each night? ______
Do you have trouble falling asleep? ❐ Yes ❐ No
Do you feel refreshed when you wake up? ❐ Yes ❐ No
Do you use medication for sleep? ❐ Yes ❐ No If so, what kind and how often?____________________

Emotional/Cognitive

❑ Do you experience an emotion/pattern often or excessively

If so, which emotions/patterns?

❑ Anger ❑ Fear ❑ Worry ❑ Sadness/Grief
❑ Joy ❑ Depression ❑ Cry Easily ❑ Frustration
❑ Mood-swings ❑ Poor memory ❑ Easily irritable ❑ Foggy thinking
❑ Explosive outbursts ❑ Difficulty making decisions ❑ Obsessive/repetitive thinking
❑ Tendency to hold things in

If you experience mood-swings, are they related to eating/not-eating? ❐ Yes ❐ No
If you are female and have mood-swings, are they related to your menstrual cycle? ❐ Yes ❐ No

Stress
List major stressors in your life:

On a scale of 0 (no stress) to 10 (freaking out), how do you rate your overall daily stress level? _________

How would you rate your level of happiness in life (scale of 1-10, 10 being the highest): _________

How would you rate your level of happiness in your job (scale of 1-10, 10 being the highest): _________

Energy Levels

Check all that apply:

❑ Are you fatigued or do you fatigue easily
❑ Do you need to take naps
❑ Do you generally feel cold
❑ Do you have cold feet and/or hands
❑ Do you catch colds frequently
❑ Do you have energy slumps at certain times of day
❑ Do you wake up tired in the morning
❑ Do you feel energized after exercise
❑ Do you regularly have a low-grade fever
❑ Does your sweat have a strong odor
❑ Do you ever wake up sweating at night
❑ Do you perspire easily without exertion
❑ Do you feel tired after meals
❑ Do you have excess/nervous energy
❑ Does your energy pick up after you get up and move about in the morning

Appetite and Digestion

Check all that apply:

❑ Has your appetite changed lately
❑ Do you have a poor appetite
❑ Are you hungry all/most of the time
❑ Do you feel foggy or low if you miss a meal
❑ Do you have abdominal (intestinal) bloating
❑ Do you experience belching/hiccups
❑ Do you have heartburn
❑ Do you have gurgling sounds in your intestines
❑ Do you have a nervous stomach
❑ Do you have intestinal gas
❑ Do you experience a bitter taste
❑ Do you have acid regurgitation
❑ Do you crave particular foods
  ❑ Sweet ❑ Salty
  ❑ Bitter ❑ Sour
  ❑ Hot or spicy
❑ Do you experience bad breath

Nutrition/Diet Information

Please describe your appetite ❒ Strong ❒ Normal ❒ Poor
Do you hunger quickly? ❒ Yes ❒ No

Please describe your diet (low fat, low-carb, vegetarian, etc.)

Please list what you ate yesterday

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

How much water do you drink per day? ____________

What is your drinking water source? ❒ Tap ❒ Bottled ❒ Filtered ❒ Reverse osmosis ❒ Distilled ❒ Well

Other fluids ______________________________

Please describe your thirst
❒ Strong ❒ Normal ❒ Poor

Exercise

Do you exercise regularly? ❒ Yes ❒ No
Please describe type & frequency/week

Other

❒ Yes ❒ No Are you presently taking steroids?
❒ Yes ❒ No Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?
❒ Yes ❒ No Have you been exposed to any known environmental toxins or hormones?

Complimentary Health Care

List any previous complimentary health care that you have participated in:

	Last visit date	*Practitioner/Reason for care*	*Treatment ongoing*
❒ Acupuncture	________	______________________	❒
❒ Massage Therapy	________	______________________	❒
❒ Chiropractic Care	________	______________________	❒
❒ Naturopathic Care	________	______________________	❒
❒ Hypnotherapy	________	______________________	❒
❒ Other	________	______________________	❒

Fertility History

How long have you been trying to conceive? ______________________________

Is there a history of difficulty conceiving or pregnancy loss in your family? ______________

Fertility History	*Dates*
❒ Pregnancies	______________________
❒ Births	______________________
❒ Miscarriages	______________________
❒ Terminations	______________________
❒ Ectopics	______________________
❒ D&C	______________________
❒ Abnormal Pap Smear	______________________

Fertility Treatments

Have you had fertility treatments? ❒ Yes ❒ No Start Date (Month/Year): ____________

If yes, are you being treated by:

❒ *RE & I Clinic/Fertility Specialist*: RMFC CCRM FCC Conceptions CU Albrecht Women's Care

Which doctor are you seeing at this clinic? ______________________

❒ *Other OBGYN doctor* ______________________

Have you had a diagnosis related to fertility? ❒ Yes ❒ No

Western Diagnosis ______________________

____

Your Diagnostics	*Date*	*Your Diagnostics*	*Date*
❒ Elevated FSH	________	❒ Low Progesterone Level	________
❒ Uterine Fibroids/Polyps	________	❒ PID	________
❒ Endometriosis/Adhesions	________	❒ Chlamydia	________
❒ PCOS	________	❒ Herpes	________
❒ POF	________	❒ Other STD's:	________
❒ Antisperm antibodies	________	❒ Other diagnostics:	________

Fertility Medications

Have you taken medication to help you ovulate? ❒ Yes ❒ No

When? ____________________ How long? ____________________

If you have been diagnosed with PCOS, are you taking

❒ Glucophage How long? _________ ❒ Fortamet How long? _________

Are you taking extra B-Complex vitamins? ❒ Yes ❒ No

Procedures performed	*Dates*	*Results*
❒ Laparoscopy		
❒ HSG (Hysterosalpingogram)		
❒ PI (Pulsatility Index)		

Have you had any tubal operations? ❒ Yes ❒ No

Lab Tests	*Dates*	*Results*
❒ FSH Level Day 3		
❒ HCG		
❒ Prolactin		
❒ TSH		
❒ T3		
❒ T4		
❒ Free T4		
❒ Free T3		
❒ OAR		
❒ Estrogen		
❒ Progesterone		
❒ Testosterone		
❒ Cholesterol		
❒ Triglycerides		
❒ Others:		

Fertility Treatments (including cancelled cycles):

Date	Natural, IUI, IVF, other	Medication used	# of mature eggs /follicles	Pregnancy Yes/No	If miscarried, what week?

Future ART Plans

	Date		Date
❒ IUI w/ injectables	______________	❒ IVF	______________
❒ IUI w/ oral meds	______________	❒ PGD	______________
❒ Clomid	______________	❒ Other:	______________

Reproductive Health

When did your last period start? ________ What day of your cycle are you on today? ________

At what age did menses begin? ________ Do you have regular pap tests? ❒ Yes ❒ No

Are you currently charting your menstrual cycles (BBT charting)? ❒ Yes ❒ No

Do you receive or give yourself regular breast exams? ❒ Yes ❒ No

Do you douche regularly? ❒ Yes ❒ No

Do you use vaginal lubricants? ❒ Yes ❒ No

Do you use tampons? ❒ Yes ❒ No

How is your sexual energy?

❒ High ❒ Normal ❒ Low ❒ None

Are you experiencing any sexual problems? ❒ Yes ❒ No

If yes, please explain: ____

Please give the following information about your periods.

How many days are there between one period and the next? _____

How many days do your periods last? ______

	Yes	No		Yes	No
Is your period regular?	❒	❒	Headaches before your period?	❒	❒
Are your periods painful?	❒	❒	Headaches after you bleed?	❒	❒
Do you bleed excessively?	❒	❒	Tightness in your chest?	❒	❒
Do you bleed too little/scanty?	❒	❒	Do you have low backache?	❒	❒
Do you discharge clots?	❒	❒	Do you tend to sigh a lot?	❒	❒

Describe menstrual flow:	❒ Heavy	❒ Moderate	❒ Light	❒ None
Color of menstrual flow:	❒ Dark	❒ Bright red	❒ Slightly reddish	❒ Brown (at beginning/end)
Clotting (mark as appropriate):	❒ Bright in color	❒ Brown/grainy	❒ Stringy	❒ Dark in color
Size of clots:	❒ Dime	❒ Nickel	❒ Larger	
Cramping (mark as appropriate)				
Where are your cramps?	❒ Low back	❒ Groin area	❒ Down legs	
When do you feel them?	❒ Before period	❒ During period	❒ During ovulation	
Severity of cramps	❒ Mild	❒ Moderate	❒ Severe	

Do you use pain medication? __________ What kind of medication? ________________________

PMS

	10 days before	1 week before	2-3 days before
Breast tenderness	❒	❒	❒
Depression	❒	❒	❒
Loose stool	❒	❒	❒
Constipation	❒	❒	❒
Fatigue	❒	❒	❒
Low back pain	❒	❒	❒
Facial break-outs	❒	❒	❒
Cravings	❒	❒	❒
Bloating/water retention	❒	❒	❒
Irritability	❒	❒	❒
Other:	❒	❒	❒

Do you have a history of:

❒ Amenorrhea
❒ Ectopic pregnancy
❒ Uterine fibroids
❒ Vaginal discharge
❒ Menstrual cramps
❒ Pelvic Inflammatory Disease
❒ Irregular periods
❒ Bleeding between periods
❒ Ovarian cysts
❒ Endometriosis
❒ Chronic vaginal or yeast infections
❒ Failure to ovulate
❒ Painful intercourse

Contraception History

Method	*Length of time used*	*How long ago?*		*Length of time used*	*How long ago?*
Pills	______	______	IUD	______	______
Patch (Ortho Evra)	______	______	Vaginal ring (NuvaRing)	______	______
Diaphragm	______	______	Rhythm method	______	______
Shot (Depo-Provera)	______	______	Fertility Awareness	______	______
Condoms	______	______	Other:	______	______

Partner Information

Partner's Name ____

Has your partner had a fertility workup? ❒ Yes ❒ No

Western Diagnosis of your partner ____

Is your partner supportive of your wish to conceive? ❒ Yes ❒ No
Does your partner experience any sexual dysfunction? ❒ Yes ❒ No

Please list all vitamins, herbs, medications that your partner is currently taking: