

Date ____/____/____	First Name	Last Name				Middle Initial
Date of Birth ____/____/____	Age:	Stress Levels:	Height:	Weight:	Activity levels:	Occupation:

LMP: _____ Cycle Duration _____

RE & I Clinic / Fertility Specialist: _____
 Other OBGYN doctor _____ Start Date: _____ Month/ Year

Western Diagnosis _____

1. Fertility treatments (including cancelled cycles):

Date	Unassisted, IUI, IVF, FET	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried, Indicate at which Week	Other Comments and Locations

2. Diagnostics / Date

Elevated FSH	Elevated Prolactin	Endometriosis / Adhesions	PCOS/ Ovarian cysts	POF	Low Progesterone Level	Fallopian Tube Occlusion	STD's	Uterine Fibroids / Polyps

Others: _____

3. Are you taking any of these medications and for how long?

Bromocriptine	Metformin	Baby Aspirin	Other Medications

4. Female Health:

PID	Chlamydia	STD's	Herpes	Antisperm Antibodies	Others

5. Procedures performed / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

6. Lab Results/ Dates

FSH Level Day 3	E2 Day3	LH Day3	CCCT Day 10 FSH	P4 Day 21	Prolactin	HCG	Others & Thyroid

7. Lab Results on File Y / N

8. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

9. Planned ART / Date:

IUI w/ Injectables	IUI w/ Oral Meds	Clomid/ Femara	IVF	PGD	Other

10. Fertility History / Dates

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

11. Other:

Age at which menses began? _____ OCP _____ How long? _____ List name of birth control _____ How long TTC? _____ Clomid challenge test? _____ Date: _____ Day 3 _____ at Day 10 _____ at _____ (month/year) Recurrent yeast infections? _____ How often? _____	Natural Ovulation Y / N Which day of your cycle _____ to _____ Typically, how many days are there from one period to the next _____ to _____ days? Today is which day of cycle? _____ Current month treatment plan _____ (Natural, IUI, IVF, Any Tests, etc.)
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9. PMS

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

10. Menstrual History

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

11. Is partner currently being treated by us?

Y / N

12. Partner's Name _____

13. Western Diagnosis of the partner: _____

14. Do we have copies of labs / sperm analysis

Y / N

15. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

16. Male Reproductive History/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / DNA	Anti- Sperm Antibodies	Others

17. Following Fertility:

Basal Body Temperature Chart	Y / N	Avoid Ice cold Foods.....	Y / N
Timed Sex	Y / N	Avoid Tampons.....	Y / N
Stress Reduction	Y / N	Femoral Massage	Y / N
Diet Principals :	<input type="checkbox"/> Yin	Visualization.....	Y / N
	<input type="checkbox"/> Yang	Meditation	Y / N
	<input type="checkbox"/> Blood	Yoga	Y / N
	<input type="checkbox"/> Qi	Qi Gong.....	Y / N
<u>Ovulation</u>		Deep Breathing.....	Y / N
LH Sticks	Y / N	Journaling.....	Y / N
OPK	Y / N	Foot Soaks.....	Y / N
Relationship / Sex	Y / N	Feminine Hygiene.....	Y / N
		Detox.....	Y / N
		Type of Detox	
		Feng Shui.....	Y / N