715 Discovery Blvd Suite. 412 * Cedar Park, TX 78613 * (512) 260-1710

Patient Name: **DOB:** **Date:**

Fertility & Menstrual History

Gynecological Exams:

- ❖ Sonogram of your reproductive organs? ☐Yes ☐No
  Results? _____
- ❖ Cervical Biopsy? ☐Yes ☐No
  Results? _____
- ❖ Hysterosalpingogram (HSG) – results: ☐Positive ☐Negative
- ❖ Hormonal Tests:
  - FSH ..... ☐Normal ☐High ☐Low
  - Estrogen, E2 ..... ☐Normal ☐High ☐Low
  - Progesterone ..... ☐Normal ☐High ☐Low
  - Prolactin ..... ☐Normal ☐High ☐Low
  - Thyroid ..... ☐Normal ☐High ☐Low
  - Testosterone ..... ☐Normal ☐High ☐Low

Previous Gynecological Surgeries:

☐Dilation & Curettage (D&C)
☐Laparoscopy (endometriosis / cysts / fibroids)
☐Hysteroscopy (results: _____)

Fertility Medications taken within last year:

Date	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with:

STDs..... ☐Yes ☐No
Pelvic Inflammatory Disease..... ☐Yes ☐No
Uterine Fibroids ..... ☐Yes ☐No
Polyps..... ☐Yes ☐No
Pelvic Adhesions ..... ☐Yes ☐No
Prolapsed Uterus ..... ☐Yes ☐No
Abnormal shape of Uterus ..... ☐Yes ☐No
Endometriosis. ..... ☐Yes ☐No
PCOS ..... ☐Yes ☐No
Unique shape of uterus..... ☐Yes ☐No
Poor Ovarian Reserve..... ☐Yes ☐No
Unexplained Infertility..... ☐Yes ☐No

Oral Contraceptives:

- ❖ Have you take oral contraceptives before? ..... ☐Yes ☐No
  If yes, for how long? _____
  When did you stop? _____
- ❖ Have you ever had an IUD?..... ☐Yes ☐No
  What type of IUD? _____

Number of: List the dates:

Pregnancies		
Cesarean Births		
Vaginal Births		
Abortions		
Miscarriages		
Failed IUI's		
Failed IVF's		
Bladder infections / year		
Yeast infections / year		

Spouse Information:

Spouse's Name: _____
Spouse's Age: _____ Spouse's Occupation: _____
Has your spouse fathered other children? _____

Sperm Analysis	
Count:	
% normal morphology:	
Motility:	

Menstrual Cycle:

What age did you start your 1st period: _____
Typical Menstrual Cycle length (ex: 26-30 days): _____
How many days do you typically bleed (do not count spotting)? _____
Date of last Menses: _____

OVULATION:

- ❖ Do you take medications to help you ovulate? ..... ☐Yes ☐No
  If yes, what kind? _____
  For how many cycles? _____
- ❖ Do you chart your cycle? (circle) BBTs / OPKs / Saliva

MENSTRUAL INFO	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Color: pale, bright red, dark red, black							
Amount of Flow: how often do you change a pad/tampon? (ie every 2, 4 hours)							
Pain /Cramps: dull , sharp, none							
Size of Blood Clots: small, medium, large, none							
Quantity of Clots: large, few, none							