

Fertility Patient Intake Form

Name: _____ Date: _____ Age: _____

Referred by: _____

1. What is the purpose of your visit today?

Preparation for pregnancy without medical intervention _____

Adjunct to assisted reproductive technology _____

2. Estimated date of procedure _____ for IVF ____ IUI ____

3. Is this your first attempt? _____ If not, how many? IVF _____ IUI ____

4. List the drugs/medications and the dates you will be taking them in preparation for your procedure: _____

5. Your attending physician/ Reproductive Endocrinologist is: _____

6. Have you had an infertility diagnosis? _____

If so, what was it? _____

7. Has your partner had his reproductive status evaluated by a physician? _____

If so, is there any male factors diagnosed? _____

8. How long have you been trying to conceive? _____

9. Have you ever gotten pregnant naturally? _____ How many times? _____

Live births _____ Abortions _____ Performed D&C _____

Miscarriages _____ How far along into the pregnancy? _____

10. Have you ever been diagnosed with any of the following gynecological diseases?

venereal disease _____ yeast infection _____ pelvic inflammatory disease _____

uterine fibroids _____ endometriosis _____ polycystic ovary _____

chlamydial infection _____ pelvic adhesions _____ uterine abnormalities _____

tubal blockage

11. Have you ever been diagnosed with hypothyroidism? _____

12. Have you been diagnosed with having abnormal prolactin level? _____

13. Have you had had your AMH or FSH levels tested? If so what were your levels?

AMH FSH

13. Have you ever used contraceptives? _____ For how long? _____

14. Date of last menstrual period _____

15. Do you spot during midcycle? _____

16. Premenstrual symptoms:

headache/migraine _____ diarrhea/ loose stools _____ fatigue _____

acne _____ night sweats _____ irritability/mood swings _____ bloating _____

nausea _____ sugar cravings _____ breast tenderness _____ abdominal cramp _____

low back pain _____ yeast _____ herpes outbreaks _____ itching _____

17. Menstruation

How many days between menstrual cycles typically (day1 to day1) ? _____

In the past 12 months, the cycle has become: Longer _____ Shorter _____ The same _____

How many days do you normally bleed? _____

In the last few cycles, the amount of bleeding has become More _____ Less _____ The same _____

Describe the color, consistency of the bleeding: Bleeding

begins brown _____

Clotting Large _____ Clotting Small _____

Bearing down sensation _____

Red _____ Brown/ Black _____

Thin red, like water _____ Thick with mucous _____

Stop and start flow _____ Spotting before/after _____ Prolonged _____

Heavy bleeding _____ Scanty bleeding _____

Piercing pain _____ Distending pain _____ Low back pain _____

Pain relieved by heating pad _____

Pain relieved with onset of the flow _____

18. Ovulation

Do you ovulate on your own? _____ On what day of the cycle? _____

Has this been confirmed with monitor _____ or BBT chart? _____

Do you notice stretchy egg white quality cervical mucous around ovulation? _____

Do you have pain during ovulation? _____

Do you breast get tender during ovulation? _____

19. Vaginal Discharge:

Do you have profuse vaginal discharge other than mid cycle cervical mucous? _____

Do you have chronic vaginal discharge? _____

20. Libido: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

21. Life Style and Dietary Habit:

Your profession: _____

Stress level (1-10) _____

Addiction: smoking _____ drug _____ alcohol _____ sugar _____ soda / diet soda _____

Describe your typical diet:

vegetarian diet _____ green leafy vegetables _____ tofu _____ juicing _____

red meat _____ fish _____ chicken _____ dairy product _____ sugar/sweets/ bakery _____

deep fried greasy foods _____ spicy, pungent foods _____ preserved foods _____

warm soup _____ chilled salads _____ fruits _____ nuts _____

Drinks:

coffee _____ soda/diet soda _____ iced water _____ fruit juice _____ alcohol _____

herbal tea _____ green tea _____ sports drink _____ milk _____ soy milk _____

Vitamins & supplements:

Yes, i.e. _____ None _____

Exercise routine: none _____ moderate _____ excessive _____

Energy level (0-10) _____ Current weight _____ Target weight _____

Emotional status:

anxiety _____ panic attacks _____ depression _____ nervousness _____

worry _____ anger _____ grief _____ fear/phobia _____ obsession _____

insomnia _____

Stress management:

acupuncture _____ massage _____ meditation _____ yoga _____

breathing exercise _____ spiritual practice _____ recreation _____