Female Fertility Intake Form

Name _____

Date of birth ____/____/____ Age _____

Street Address

_____

City _____

State _____ Zip _____

Phone _____

Email address _____

Marital Status _____

Number of Children _____

General

Height_____

Weight_____

Emotional/Cognitive

☐ Do you experience an emotion/pattern often or excessively If so, which emotions/patterns?

☐ Anger
☐ Joy
☐ Mood-swings
☐ Explosive outbursts
☐ Difficulty making decisions
☐ Obsessive/repetitive thinking
☐ Tendency to hold things in

☐ Fear ☐ Worry ☐ Sadness/Grief
☐ Depression ☐ Cry Easily ☐ Frustration
☐ Poor memory ☐ Easily irritable ☐ Foggy thinking

Are your mood-swings on or around your menstrual cycle?
_____

Fertility History

How long have you been trying to conceive?
_____

Fertility History

☐ Pregnancies ☐ Births
☐ Miscarriages ☐ Terminations ☐ Ectopics

☐ D&C
☐ Abnormal Pap Smear

Fertility Treatments

Dates

_____
_____
_____
_____

Have you had fertility treatments? ☐ Yes ☐ No

Start Date: _____ Month/Year
Have you had a diagnosis related to fertility? ☐ Yes ☐ No
Western Diagnosis
_____

Your Diagnostics

☐ Elevated FSH
☐ Uterine Fibroids/Polyps

☐ Endometriosis/Adhesions

☐ PCOS

☐ POF
☐ Antisperm antibodies

Fertility Medications

Have you taken medication to help you ovulate?

☐ Yes ☐ No

If you have been diagnosed with PCOS, are you taking

☐ Glucophage How long? _____

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

How long? _____

❒ Laparoscopy _____

Have you had any tubal operations? ☐ Yes ☐ No

Lab Tests

☐ FSH Level Day 3 ☐ HCG
☐ Prolactin
☐ TSH
☐ T3
☐ T4
☐ Free T4
☐ OAR

☐ Others:

Reproductive Health

When was your last period? _____

What day of your cycle are you on today? _____

At what age did menses begin? _____

How many days are there between one period and the next?
How many days do your periods last? _____

Do you have regular pap tests? ☐ Yes ☐ No

Are you currently charting your menstrual cycles? ☐ 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? Yes ☐ No ☐
☐ High ☐ Low ☐ Normal ☐ None ☐

Are you experiencing any sexual problems? Yes ☐ No ☐

Is your period regular? Yes ☐ No ☐

Are your periods painful? Yes ☐ No ☐

Do you bleed excessively? Yes ☐ No ☐

Do you bleed too little/scanty? Yes ☐ No ☐

Do you discharge clots? Yes ☐ No ☐

Do you have headaches before your period? Yes ☐ No ☐ Do you get headaches after you bleed? Yes ☐ No ☐

Do you experience tightness in your chest? Yes ☐ No ☐

Do you experience low backache? Yes ☐ No ☐

Do you tend to sigh a lot? Yes ☐ No ☐

Describe menstrual flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None ☐
Color of menstrual flow:

☐ Dark ☐ Bright red ☐ Slightly reddish
☐ Brown (at beginning/end of period)

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	☐	☐	☐
Water retention	☐	☐	☐
Irritability	☐	☐	☐
Other:	☐	☐	☐

Do you have a history of:

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

Contraception History
Method
Length of time used?
How long ago?

☐ Pills
☐ Patch (Ortho Evra)
☐ Diaphragm
☐ Shot (Depo-Provera)
☐ Condoms
☐ IUD
☐ Vaginal ring (NuvaRing)
☐ Rhythm method
☐ Fertility Awareness Method

Other:_____

Nutrition/Diet Information

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? _____
Other fluids _____
Please describe your thirst

☐ Strong ☐ Normal ☐ Poor

Supplements/Vitamins
Are you taking any of the following:

☐ Prenatal Vitamin (Brand: _____)

☐ Fish oil (Brand: _____)

☐ Antioxidants

☐ Royal Jelly/Propolis

☐ Additional Folic Acid

☐ Others:

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