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Date _____

510.883.0383

Confidential intake of Women's Fertility History

(Feel free to skip any questions that do not pertain to your partner, if you are using a donor)

Name _____ Best number to reach you _____

Current Age _____ Birthdate _____ Height _____ Weight _____

Current Medications, Herbs or Supplements _____

Are you allergic to any medications? Yes No

Are you currently seeing a Reproductive Endocrinologist? Yes No

Name _____ Phone Number _____

Are we authorized to contact your RE with any questions we may have? Yes No

Will you be trying to get pregnant naturally, with an IUI or IVF procedure? _____ When? _____

Have you ever been pregnant? Yes No When? _____

What was the result of those pregnancies? _____

How long have you been trying to have a child? _____

Have you gone through an IUI or IVF? Yes No What was the result? _____

Are you ovulating? _____ If so, how do you know? _____

Do you have cervical mucus (egg white)? Yes No Do you have pain with ovulation? Yes No

Are you tracking your temperatures with BBT? Yes No (If you have, please bring these with you.)

Have you ever been on the birth control pill, when and how long? _____

Have you had an HSG? Yes No Have you been diagnosed with any pelvis abnormalities? Yes No

Do you experience pain with deep penetration during intercourse? Yes No

Are your breasts healthy? Yes No Do you have any secretions from your nipples? Yes No

Please fill in the following from the last 6 months (and bring any blood tests you have with you):

FSH _____ LH _____

Estradiol _____ Progesterone (7DPO) _____

Have you had or have any of the following (circle what applies):

Endometriosis Yes No Past Current _____
Uterine Fibroids Yes No Past Current _____
Ovarian Cysts Yes No Past Current _____
Polyps Yes No Past Current _____
HPV Yes No Past Current _____
STD's Yes No Past Current _____
Yeast Infections Yes No Past Current _____
PCOS Yes No Past Current _____
Fibrocystic Breast
Disease Yes No Past Current _____
Abnormal PAP Yes No Past Current _____

Check any below that you or a family member have had:

Stroke (before the age of 65) Yes No
Heart attack (before the age of 65) Yes No
Thyroid Disorder Yes No
Rheumatoid arthritis Yes No
Lupus Yes No

Any other autoimmune or thrombophilic diseases? Explain _____

Has there been any blood female in your family that has had trouble conceiving? Yes No

Explain _____

Has any blood female in your family had a miscarriage? Yes No _____

Do you drink alcohol? Yes No How often? _____

Do you smoke cigarettes? Yes No How often? _____

Do you drink caffeine? Yes No What kind? _____ How much? _____

Do you take any recreational drugs? Yes No How often? _____

Would you say you eat healthy? Yes No

What is your exercise regimen? _____

What is your stress level? (Circle) Very high High Moderate Light None

Has your male partner ever impregnated someone? Yes No When? _____ Birth? Yes No

Please fill in the following:

Sperm Volume _____

Sperm Morphology _____

Sperm Motility _____

Sperm Count _____

Any DNA testing? Yes No