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

**Fertility & Menstrual History**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Gynaecological 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  Oestrogen, E2 ........... . □Normal □High □Low   + Progesterone ........... □Normal □High □Low  Prolactin ................... □Normal □High □Low   + Thyroid ..................... □Normal □High □Low  Testosterone .......... □Normal □High □Low     **Previous Gynaecological 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 |  |  | | Caesarean 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 |

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