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

**Fertility & Menstrual History**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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
 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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  |   |   |   |   |   |   |   |