Healing InSight

Reproductive Health & Fertility History

Please take time to thoughtfully and honestly answer these questions so we're able to develop an individualized diagnosis and treatment plan that's right for you.

Female Patient Name: _____ Date of Birth: _____

What are your expectations for this visit? _____

How many months have you been having intercourse without any form of birth control? _____ N/A

Menstruation history:

What is your menstrual cycle pattern? (Check all that apply)

□ Regular □ Irregular □ Spotting before period □ Circle Spotting Color: Pink / Red / Brown
□ Spotting after period □ Circle Spotting Color: Pink / Red / Brown □ Bleeding between periods
□ Light/Heavy periods □ Period lasts less than 3 days □ Period lasts more than 10 days
□ No periods When did you stop having them? _____

How many days are between periods? _____
How many days of bleeding do you have? _____
List the dates of 1st day of your last two menstrual periods: ___/___/___ ; ___/___/___
How many periods do you have a year? _____
Do you need medication to bring on a period? Y / N If yes, what type? _____

Pregnancy summary:

Total number of ALL pregnancies: _____ How many children have you had? _____ Number of miscarriages (<20 wks): _____
Number of abortions: _____ Number of full-term deliveries: _____ Number of premature (<37 wks) deliveries: _____

Date pregnancy ended or delivered	Months to conception	Treatments to conceive	Delivery type - D&C complications	Current partner?
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N

Contraceptive and sexual history:

□ None □ Condoms (Dates of use) _____ □ Injectable contraception (Dates of use) _____
□ Birth control pill (Dates of use) _____ Name of Contraceptive Pill: _____
□ Continuous use (no monthly bleeding) □ Monthly withdrawal bleeding
□ IUD □ Circle Hormonal / Copper (Dates of use) _____
□ NuvaRing (Dates of use) _____ □ Diaphragm (Dates of use) _____
□ Never used birth control pills
□ Other forms of birth control _____
□ List any complications: _____

Are you sexually active? ___Yes ___No How many times do you have intercourse per week? ___ WK ___ None ___ N/A
Have you used over the counter ovulation kits to time intercourse? ___ Yes ___ No ___ Unable to get LH Surge Positive
Are you using a wearable device? If so, what kind? _____
Are you using any other tracking technology? If so, what kind? _____
Do you have pain with intercourse? ___ Yes ___ No Use lubricants (K-Y Jelly, etc) during intercourse ___ Yes ___ No

Have you ever had an abnormal pap smear? ___ Yes ___ No If Yes When _____
Have you ever had a cervical biopsy? ___ Yes ___ No

Have you ever been diagnosed with a chlamydial infection? ___ Yes ___ No If yes, When _____
Do you have any history of sores on your genitalia? ___ Yes ___ No
Have you ever had pelvic inflammatory disease (PHD)? ___ Yes ___ No If yes, Were you treated for it? ___ Yes ___ No
Have you ever been diagnosed with uterine fibroids or polyps? ___ Yes ___ No, When/Treatment: _____
Have you ever been diagnosed with endometriosis? ___ Yes ___ No, When/Treatment: _____
Have you ever been diagnosed with pelvic adhesions? ___ Yes ___ No, When/Treatment: _____
Have you ever been diagnosed with any pelvic abnormalities? ___ Yes ___ No, When/Treatment: _____

Have you had any prior infertility testing or/and treatment? ___ Yes ___ No
What clinic have you been seen at? _____
Name of Physician / R.E. / OBGYN / Midwife: _____
What is your infertility Diagnosis? _____

Prior Tests (check all that apply)

□ Basel body temperature chart -Date: _____ Results: _____, (bring your BBT Charts @1st visit)
□ Are you tracking BBT using an app? If so, which one? _____
□ Thyroid test -Date: _____ Results: _____ □Day 3 Blood test for FSH -Date: _____ Results:_____
□ Progesterone blood test -Date: _____ Results: _____ □Prolactin blood test -Date: _____ Results: _____
□ Hysterosalpingogram (HSG) –Date: _____ Results: _____
□ Hysteroscopy surgery –Date: _____ Results: _____ □Laparoscopy surgery –Date: _____ Results: _____

Prior Treatment (Fill in all that apply)

Treatment Type	# of Cycles	Date From (mo/yr) to mo/yr)	Outcome
Intrauterine Insemination (IUI)		To	Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant
Clomid with Time Intercourse		To	Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant
Clomid with Insemination (IUI)		To	Pregnant: Delivered/Ectopic/Miscarriage _No Pregnant
Daily Fertility Drug Injections with (IUI)		To	Pregnant: Delivered/Ectopic/Miscarriage _No Pregnant
Completed In Vitro Fertilization (IVF) Cycle(s) 1. # Eggs__ #Embryos Transferred__ #Frozen__ 2. # Eggs__ #Embryos Transferred__ #Frozen__ 3. # Eggs__ #Embryos Transferred__ #Frozen__ 4. # Eggs__ #Embryos Transferred__ #Frozen__		 _____/_____ _____/_____ _____/_____ _____/_____	 Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant
Frozen Embryo Transfers 1. # Embryo Transferred _____ 2. # Embryo Transferred _____ 3. # Embryo Transferred _____		 _____/_____ _____/_____ _____/_____	 Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant Pregnant: Delivered/Ectopic/Miscarriage _Not Pregnant
Canceled IVF Attempt(s)			
Any Other Prior Treatment (Describe):			

Is your partner supportive of your wish to conceive? ___ Yes ___ No
Is your partner supportive of your infertility treatments? ___ Yes ___ No; Describe: _____
On a scale of 1-10 (10=worst), estimate the level of stress you feel due to infertility: _____
Describe any emotional, marital or sexual problems caused by your infertility: _____
_____

Do you have a future IUI or IVF procedure scheduled? ___ Yes ___ No; If yes, list the dates

Last day of Birth Control Pill _____/_____/_____ First day of Stimulation Medication _____/_____/_____
Date (the week) of IUI _____ Date (the week) of IVF retrieval: _____/_____/_____
Date (the week) of Frozen Embryo Transfer (FET) _____

Do you have any other comments? _____
_____

Male Patient (Partner) Name: _____ Date of Birth: _____

Have you ever seen an Urologist for evaluation? ____ Yes ____ No When: _____
Physician Name: _____

Have you had a semen analysis? ____ Yes ____ No Please list recently results

Date	Volume	Count	Motility	Morphology	Comments
1.					
2.					
3.					

Have you ever fathered any prior pregnancies? ____ Yes ____ No Outcome: _____
How would you define your sexual energy? Below Normal ____ Normal ____ High ____
Do (or did) you have an undescended testicle? ____ Yes ____ No Comments: _____
Have you ever been diagnosed with a varicocele? ____ Yes ____ No Comments: _____
Have you ever had any urologic surgeries? ____ Yes ____ No Comments: _____
Have you experienced erectile dysfunction? ____ Yes ____ No Comments: _____
Have you had exposure to any known environmental toxins or hormones? ____ Yes ____ No Comments: _____
Do you regularly experience nocturnal emission? ____ Yes ____ No Comments: _____
Do you have high cholesterol? ____ Yes ____ No Comments: _____
Have you ever had a spinal injury? ____ Yes ____ No Comments: _____
Have you experienced a high fever in the last 6 months? ____ Yes ____ No Comments: _____
Do you currently have any prostate conditions? ____ Yes ____ No Comments: _____
Have you had your testosterone levels checked? ____ Yes ____ No Comments: _____
Have you ever taken testosterone supplements/drugs? ____ Yes ____ No Comments: _____

Do you smoke? ____ Yes ____ No How many a day? _____ How many years? _____ Quit when? _____
Do you drink? ____ Yes ____ No How many drinks per week? _____
Have you casually used marijuana, cocaine, or any similar drug? ____ Yes ____ No Describe: _____

Have any of your immediate family members had difficulty conceiving a child? ____ Yes ____ No Describe: _____
_____

On a scale of 1-10 (10 = worst), estimate the level of stress you feel due to infertility: _____ Due to work: _____

List your current medical problem(s): _____

List your current medications: _____

List your current herbs, vitamins or health store supplements: _____

Do you have any other comments? _____