Fertility Treatment Form

General Information Date: _____

Name: _____ Age:

Fertility doctor/Reproductive Endocrinologist: _____

Fertility clinic: _____

Western Medical Diagnosis: _____
_____

How long have you been trying to conceive? _____

Western Diagnostic Tests. Check all that apply and give Dates

Thyroid Test	Date _____/_____/_____
Clomid Challenge	Date _____/_____/_____
Hormonal Levels: FSH, LH, Estradiol, etc.	Date _____/_____/_____
Endometrial Biopsy	Date _____/_____/_____
Hysterosalpingogram	Date _____/_____/_____
Hysteroscopy	Date _____/_____/_____
Ultrasound	Date _____/_____/_____
Genetic Screening	Date_____/_____/_____

Please check any Diagnoses below that apply:

__ High FSH
__ PCOS
__ Unexplained Infertility
__ Uterine Polyps/fibroids
__ Endometriosis
__ Low Progesterone
__ Pelvic Infection (PID)
__ Premature Ovarian Failure
__ Unstable Luteal Phase
__ Other

Check any below that apply and please give dates

Ectopic pregnancy _____	Date _____/_____/_____
Miscarriages _____	Date_____/_____/_____
Abortion _____	Date _____/_____/_____
D & C _____	Date _____/_____/_____
Abnormal Pap _____	Date _____/_____/_____

Has your husband/partner been checked for sperm quality? _____

Do you get:
Recurrent yeast infections? Yes_____ No _____

UTI's? Yes _____ No _____

Have you ever had Chlamydia or any STD's? Yes _____ No _____

Date of Last Menstrual Period? _____

IUI: Dates and Outcomes:

_____

_____

_____

IVF: Dates and Outcomes:

_____

_____

_____

Is there any other information that may be helpful?

_____

_____