FIVE SEASONS FERTILITY INTAKE

Name ____Birthdate ___________________

How long have you been trying to conceive ____

____

Have you had a diagnosis relating to infertility? Yes No ________________________________

____

PREVIOUS FERTILITY TREATMENTS

Where ______________________________________ Dr. _________________________________

When and Type ____

Where ______________________________________ Dr. _________________________________

When and Type ____

Medication to promote ovulation (when and type) ______________________________________

____

Oral contraceptives (type and length)____

IUD ____

Fallopian tube evaluation Results____

Tubal operations ____

Hormone lab tests:____

Genetic tests____

Other tests or procedures ____

D&C ____

Last Pap _________________   Any Abnormal PAP _____________________________________

Pelvic Inflammatory Disease PID ____

Cervical biopsy, operation, cauterization or conization __________________________________

Endometriosis or pelvic adhesions ____

Uterine Fibroids or polyps ____

PCOS or ovarian cysts ____

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CYCLE INFORMATION

First day of Last Cycle? ________________ Days between cycles ___________________________

Have cycles changed since they began? ____

Regularity during last year ____

Any pain, cramping, discomfort? ____

How long does it last? ____

Length and Pattern of flow ____

____

Color - Bright red, red, dark red, purple, brown black **Flow** - Light, Normal, Heavy

Clotting - when and how long ____

PREMENSTRUAL SYMPTOMS

Irritable, depressed, breast tenderness, cramping, low back pain, constipation,

Other PMS symptoms ____

Do you have sensations or bleeding at ovulation? ____

Spotting between periods? ____

GYN HISTORY

Pregnancies? What years? ____

Terminations ____________________________Miscarriages __________________________________

Regular yeast or urinary tract infections?____

Chronic vaginal discharge______________________Herpes _______________________________

Sexual energy: Low Normal High ____

Douche regularly? ___________ With what ____

Vaginal Lubricants? ____

Excess facial or body hair___________________ Excessively oily Skin_______________________

Mother exposed to DES (diethylstilbestrol) when pregnant with you? ________________________

Exposed to any known environmental toxins or hormones? _________________________________