

Women's Fertility History (continued)

Have you had fertility treatments? Yes or No

If yes, where and when? _____

By whom? _____

What types? _____

Have you taken medication to help you
Ovulate? Yes or No

When? _____

How long? _____

Have your fallopian tubes been evaluated
Medically? Yes or No

What were the results? _____

Have you had any hormone laboratory tests
Performed? Yes or No

What were the results? _____

Do you have a single partner with whom you

You have been trying to conceive? Yes or No

How long have you been trying to conceive?

Has he had a fertility workup? Yes or No

What were the results? _____

Is your partner supportive of your wish to
Conceive? Yes or No

Have you taken oral contraceptives?
Yes or No

When? _____ How long? _____

Have you ever had an IUD? Yes or No

When? _____ How long? _____

How is your sexual energy? Low/ Normal/ High

Do you douche regularly? Yes or No

With what? _____

Do you use vaginal lubricants? Yes or No

Are you more than 20% over your ideal body weight?
Yes or No

Are you more than 20% below your ideal body weight?
Yes or No

Do you have a stressful occupation? Yes or No

Do you feel like you are constantly stressed? Yes or No

Do you exercise regularly? Yes or No

Have you had any tubal operations? Yes or No

Do you have excessive facial hair? Yes or No

Do you have excessively oily skin? Yes or No

Have you experienced excessive head hair loss?
Yes or No

Have you noticed any discharge from your nipples?

Yes or No

Was your mother exposed to diethylstilbestrol when
she was pregnant with you? Yes or No

Have you been exposed to any known environmental
toxins or hormones? Yes or No

Are you presently taking steroids? Yes or No

Have you ever taken DepoProvera? Yes or No

When? _____ How long? _____

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

What was it? _____

Comments/notes