

## Women's Fertility History

Name of your fertility doctor/specialist: \_\_\_\_\_ Start date: \_\_\_\_\_

1. Please list below all pregnancies & fertility treatments (including canceled cycles)

Date	Natural, IUI, IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes / No	If Miscarried, At which week?	Other Comments

2. Do you have any of these diagnoses?

	High FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level
Date						

3. Have you ever had any of these infertility tests or procedures?

	Laparoscope	HSG-Hysterosalpingography	Others:
Date(s):			

4. Do you have any of these in your history? If yes, please list how many.

Pregnancies	Children	Miscarriages	Abortions	Ectopic	D&C	Abnormal Pap Smear	Others

5. Other

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6. List PMS symptoms **before** your period:

7. How is your period each day? Please note each day.

	10 Days Before	1 Week Before	2-3 Days Before	Symptoms (Check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Breast Tenderness				Back Pain?						
Depression				Cramping? (Lt, Med, Severe)						
Fatigue				Color? (Lt Red, Red, Dark Red, Brown)						
Low Back Pain				Flow Quantity? (Lt, Normal, Heavy)						
Face Breaks Out				Clotting?						
Other				Spotting?						