Patient Name:_____ **Date:**_____

Name of doctor or fertility specialist:_____

Have you had fertility treatments? Yes□ No□

How long have you been trying to conceive:_____

Has your husband/partner had a fertility work up? If so, when?_____

What were the results:_____

Is your husband/partner currently on or taken in the past Finasteride (Propecia)? If so, when?_____

During which day of your cycle do you ovulate:_____

What method do you use to determine ovulation:_____

_____

Do you have any pain or cramping during ovulation?_____

Do you have to do a Clomid challenge test? _____at Day 3. _____at Day 10. _____at _____(month/year)

Have you done BBT testing? Yes□ No□

How many D&C's have been performed? _____

How is your sexual energy? □Low □Normal □High

Do you use vaginal lubricants? Yes□ No□

Are you more than 20% below your ideal body weight? Yes□ No□ More than 20% over? Yes□ No□

Do you have oily skin? Yes□ No□

Do you have excessive facial hair? Yes□ No□ Does hair grow around your nipples? Yes□ No□

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

Have you taken oral contraceptives? Yes□ No□ When?_____ How long?_____ What kind?_____

Have you had a diagnosis related to infertility? Yes□ No□ What was it?_____

Please list all fertility treatments and pregnancies below:

Date	Natural, IUI, IVF, Other	Medications Used	# of Mature Eggs/ Follicles	Pregnancy Y/N	If miscarried, indicate at which week

Please indicate any levels that are above or below normal range:
□AMH_____□FSH_____□E2_____□Progesterone_____□Testosterone_____

Please indicate if you have had any of these fertility tests or procedures and the date of the procedure:
□Laparoscopy_____□HSG – Hysterosalpingogram_____□Saline sonogram_____