

Women's Fertility History

Name of Current Infertility Physician: _____

Phone Number of physician: _____

Have you had fertility treatments? Yes No

If yes, please fill out the following chart:

Treatment with **Assisted Reproductive Technology**:

Cycle #	Protocol	Date and # of Eggs Retrieved	Quality of Eggs	Date and Name of Injectibles or Drugs	Date of Implantation	Date and # Of Embryos Transferred	Alternative treatments Used (Acupuncture, Herbs, etc.)	Pregnant?	Delivery?

Length of time attempting pregnancy? _____

Length of time not using contraceptives? _____

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

Have you taken medication to help you ovulate? Yes No

Have your fallopian tubes/uterus been evaluated medically? Yes No

Hysterosalpingogram (x-ray of tubes and uterus) Yes No

Hysteroscopy (looking inside uterus) Yes No

Endometrial biopsy (taking tissue from inside uterus) Yes No

Have you had any tubal operations? Yes No

Laparoscopy (looking inside the abdomen) Yes No

Have you had any hormone laboratory tests performed? Yes No

Are you recording BBT Charts? Yes No

Have you had a post-coital test (to test sperm in cervical mucous) Yes No

Do you have a single partner with whom you are trying to conceive? Yes No

How long have you been married/living together? _____

Has he had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

Have you taken oral contraceptives? Yes No

Have you ever had an IUD? Yes No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No

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