Women's Fertility History

Name of your fertility doctor/specialist: _____ Start date: _____

1. Please list below all pregnancies & fertility treatments (including cancelled 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

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	Day5	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?						