

## Fertility Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete this health history indicating test results, dates of test and any side effects to medications.

Western Medical Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Western Medical Diagnostic Test and Hormone Panels: (include test date and results):

Hysterosalpingogram (HSP):

Endometrial Biopsy:

Clomid Challenge:

Follicle Stimulating Hormone (FSH):

Leutinizing Hormone (LH):

Estradiol:

Progesterone:

Prolactin:

Any additional tests:

Gyn-Related Surgeries: (Include dates and results): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Male Partner Information:

Has your partner completed screening tests?

Is your partner currently being treated?

Is your partner willing to consider treatment?

Western Medical Diagnostic Tests: (Include dates and results):

Sperm Morphology:

Sperm Motility:

Sperm Count:

Assisted Reproductive Therapy:

Please indicate procedures, dates of procedures, medications, any side effects, quality and quantity of eggs produced, size of eggs, number of cells and results

IUI: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IVF: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian transfer (ZIFT):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any other treatments, conventional and alternative:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any other information you think is important for me to know:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_