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Patient Name: **DOB:** **Date:**

Fertility & Menstrual History

Gynaecological Exams:

❖ Sonogram of your reproductive organs? ☐Yes ☐No
Results? ______________________________

❖ Cervical Biopsy? ☐Yes ☐No
Results? ______________________________ ❖
Hysterosalpingogram (HSG) – results: ☐Positive ☐Negative ❖
Hormonal Tests:

- FSH .... ☐Normal ☐High ☐Low
- Oestrogen, E2 .... ☐Normal ☐High ☐Low
- Progesterone .... ☐Normal ☐High ☐Low
- Prolactin .... ☐Normal ☐High ☐Low
- Thyroid .... ☐Normal ☐High ☐Low
- Testosterone .... ☐Normal ☐High ☐Low

Previous Gynaecological Surgeries:

☐Dilation & Curettage (D&C)
☐Laparoscopy (endometriosis / cysts / fibroids)
☐Hysteroscopy (results: ______________________________)

Fertility Medications taken within last year:

Date	Medication
________	______________________________
________	______________________________
________	______________________________
________	______________________________
________	______________________________
________	______________________________

Have you ever been diagnosed with:

STDs...................................... ☐Yes ☐No
Pelvic Inflammatory Disease............... ☐Yes ☐No
Uterine Fibroids .... ☐Yes ☐No
Polyps.. ☐Yes ☐No
Pelvic Adhesions ....☐Yes ☐No
Prolapsed Uterus .... ☐Yes ☐No
Abnormal shape of Uterus .... ☐Yes ☐No
Endometriosis. .... ☐Yes ☐No
PCOS .... ☐Yes ☐No
Unique shape of uterus........................ ☐Yes ☐No
Poor Ovarian Reserve.......................... ☐Yes ☐No
Unexplained Infertility.......................... ☐Yes ☐No

Oral Contraceptives:

❖ Have you take oral contraceptives before? .... ☐Yes ☐No
If yes, for how long? ______________________________
When did you stop? ______________________________

❖ Have you ever had an IUD?..☐Yes ☐No
What type of IUD? ______________________________

Number of: List the dates:

Pregnancies		
Caesarean Births		
Vaginal Births		
Abortions		
Miscarriages		
Failed IUI's		
Failed IVF's		
Bladder infections / year		
Yeast infections / year		

Spouse Information:

Spouse's Name: ______________________________
Spouse's Age: ______ Spouse's Occupation: __________________
Has your spouse fathered other children? ______________________

Sperm Analysis	
Count:	
% normal morphology:	
Motility:	

Menstrual Cycle:

What age did you start your 1st period: _________
Typical Menstrual Cycle length (ex: 26-30 days): _________
How many days do you typically bleed (do not count spotting)? _________
Date of last Menses: ________________

OVULATION:

❖ Do you take medications to help you ovulate? .... ☐Yes ☐No
If yes, what kind? ______________________________
For how many cycles? ______________________________

❖ Do you chart your cycle? (circle) BBTs / OPKs / Saliva

MENSTRUAL INFO	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7

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Colour: pale, bright red, dark red, black							
Amount of Flow: how often do you change a pad/tampon? (i.e. every 2, 4 hours)							
Pain /Cramps: dull , sharp, none							
Size of Blood Clots: small, medium, large, none							
Quantity of Clots: large, few, none							