

FERTILITY SUPPLEMENTAL FORM
SECTION 1: FEMALE FERTILITY QUESTIONS:

Name: _____ Date: _____

Do you know your LABS?

FSH (Follicular Stimulating Hormone):

LH (Luteal Hormone):

AMH (Anti-mullerian Hormone):

Do you have history of PCOS (Polycystic Ovary Syndrome) or Endometriosis?

YES

NO

Do you use recreational drugs or drink alcohol? YES NO

Have you ever been pregnant? YES NO

If yes, how many times? _____ Have you had any miscarriages? YES NO

Have you had any abortions? YES NO

SECTION 2: PERIOD QUESTIONS

Date of Last Period:

Are your periods regular? YES NO

How many days do you bleed?

Would you consider your cycle to be heavy, light, or medium?

Do you pass clots? YES NO

Do you spot prior to or after periods? YES NO

SECTION 3: OVULATION QUESTIONS

Do you ovulate on your own? YES NO Don't Know

What day of your cycle do you typically ovulate?

Do you get stretchy discharge during this time? YES NO Don't Know

Do you have timed intercourse? YES NO

If you plan to work with a Reproductive Endocrinologist, please continue to fill Section 4. If not, please continue with Section 5.

SECTIONS 4: IVF/IUI/FET

Have you ever had a fertility procedure in the past? If so, which procedure and what were the results?

When are you planning to start your fertility procedure?

Who is your Reproductive Endocrinologist?

Do you know what medications you will be put on?

Are you using egg donor or donor sperm? YES NO

SECTION 5: MALE FERTILITY QUESTIONS

Are there any sperm quality concerns?

If so, we suggest also seeing your male partner for acupuncture. Please contact the office to discuss a couple's acupuncture consultation/treatment.

Do you work with any chemicals? YES NO

LABS: Motility:

Morphology:

Count:

Concentration:

Do you use recreational drugs or drink alcohol? YES NO

THANK YOU