Fortune Fertility & Acupuncture Center
2007 Village Run Rd., Wexford, PA 15090
www.FortuneFertility.com
(724) 799-8393

Name: _____ Date: _____ Age: _____

Fertility Treatment

The purpose of your visit:

- ☐ Trying to be pregnant naturally without medical intervention
- ☐ Complementary therapy for ART (Assisted Reproductive Technology):
  - ☐ IUI ☐ IVF ☐ IVF with Donor Egg ☐ Frozen Embryo Transfer

  Estimated date of procedure: _____

Your Reproductive Endocrinologist or OB/GYN (if applicable):

Name: _____

Phone Number: _____

How many times have you had each/any of these procedures?

IUI: _____ IVF: _____ Other: _____

Have you taken medication to help you ovulate?

When: _____ How long: _____

Have your fallopian tubes been evaluated medically?

Results: _____

Have you had any tubal operations?

When: _____

Have you had any hormone lab tests performed (i.e. Day 3 FSH)?

Results: _____

Schedule of FERTILITY drugs to be used in current or projected cycles (if applicable):

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Medical History (Check the following if they apply to you.):

- ☐ Fibroids
- ☐ Endometriosis
- ☐ POF (premature ovarian failure)
- ☐ PCOS (policystic ovarian disease)
- ☐ Thin uterine lining
- ☐ Ovarian hyperstimulation
- ☐ Hostile cervical mucous
- ☐ Ovarian cysts
- ☐ Tubal pregnancy
- ☐ Fetal genetic abnormalities
- ☐ Thyroid
- ☐ Uterine anatomical abnormalities
- ☐ Pelvic adhesions
- ☐ Antiphospholipid antibodies
- ☐ PID (pelvic inflammatory disease): If yes, were you treated for it? ☐ yes ☐ no
  How: _____
- ☐ Oral contraceptive use: If yes, how many years? _____ How long ago did you stop? _____
- ☐ "Poor responder" to fertility drugs: If so, which ones were used and when?
  _____
- ☐ Miscarriage: If yes, how many times? _____ At what week? _____
- ☐ abortion(s)

Progesterone level in normal range? ☐ yes ☐ no
HSG/test for blocked tubes? ☐ yes ☐ no If yes, are tubes open? ☐ yes ☐ no
Have you had a midcycle vaginal ultrasound? ☐ yes ☐ no results: _____
Post-coital vaginal ultrasound? ☐ yes ☐ no

Menstruation Info

Your age at which menses began: _____
How many days are there from one period to the next (menstrual cycle)? _____
Are your periods painful? ☐ yes ☐ no How many days does the pain last? _____
How many days do you normally bleed? _____
How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy
What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black
Is there clotting? ☐ yes ☐ no
Do you have premenstrual tension? ☐ yes ☐ no
Does your face break out before or during your period? ☐ yes ☐ no
Do your breast become tender premenstrually? ☐ yes ☐ no
Do you bleed or spot between periods? ☐ yes ☐ no
Are your menstrual cycles spaced irregularly? ☐ yes ☐ no
Date of last menstrual period: _____
How many pregnancies have you had? Number: _____ Year: _____
How many children do you have? _____
How many abortions have you had? _____
How many times has a D&C been performed? _____

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Have you ever conceived naturally in the past? □ yes □ no with this partner? □ yes □ no
Have you ever had a venereal disease? □ yes □ no
Do you get yeast infection regularly? □ yes □ no
Do you have chronic vaginal discharge? □ yes □ no
Do you have sores on your genitalia? □ yes □ no
Have you ever had an abnormal pap smear? □ yes □ no
Date of last pap smear: _____

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How Long

Vitamin supplements, prescriptions, and over-the-counter drugs currently being used unrelated to fertility treatment:

_____

_____

Do you get premenstrual low back pain? □ yes □ no
Do your bowel movements become loose at the beginning of your period? □ yes □ no

Life Style

How long have you been trying to conceive?
Have you had a diagnosis relating to infertility? □ yes □ no
Results: _____
Has your partner had a fertility workup (e.g. sperm analysis)? □ yes □ no
Results: _____
Have you ever had Depo Provera? □ yes □ no When _____ How long _____
Have you ever had an IUD? □ yes □ no When _____ How long _____
How is your sexual energy? □ Low □ Normal □ High
Do you use vaginal lubricants? □ yes □ no
Are you more than 20% over your ideal body weight? □ yes □ no
Are you more than 20% below your ideal body weight? □ yes □ no
Do you have a stressful occupation? □ yes □ no Do you exercise regularly? □ yes □ no
Do you smoke? □ yes □ no Are you currently taking steroids? □ yes □ no