Fertility Intake Form

Urban Wellness & Fertility Toronto
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Fertility Health History

Name: _____ Date: _____

Age of your first menstrual cycle? _____Are your periods painful? _____ How many days does the pain last? _____ How many days do you usually bleed? _____ How heavy? _____ What color is the blood? ( ) light red ( ) red ( ) dark red ( ) purple ( ) brownIs there clotting? _____What are your premenstrual symptoms?_____ Do you get acne breakouts before or during your period? _____Do your breasts become tender premenstrually? _____ How many days from one period to the next? _____ Date of last period _____

Have your cycles changed since they began? _____ Do you get yeast infections regularly? _____Have you ever had Pelvic Inflammatory Disease? _____

Date of last pap smear _____ Have you had an abnormal pap smear? _____ Have you had a cervical biopsy, operation or cauterization? _____ Have you been diagnosed with uterine fibroids? _____ endometriosis? _____

Date of last mammogram _____ Have you had an abnormal mammogram? _____ Do you do a monthly breast self-exam? _____

What types of contraception do you or have you used in the past? How long did you use each?

_____
_____

Between periods, how much discharge do you have, if any? _____ Is it thin or thick? _____ Does it have a color? _____ An odor? _____

How many pregnancies have you had? ___ How many children do you have? _____ Have you had an abortion? _____ Miscarriage? _____ D&C? _____

How long have you been trying to get pregnant? _____Have you had a diagnosis relating to fertility? _____

Please be assured that your information is confidential and will be shared only with your practitioners.

Have you had fertility treatments? If so, what treatment and when?

_____

Have you taken medication to help you ovulate? If so, when and how long?

_____

Have your fallopian tubes been evaluated medically? If so, what were the results?

_____

Have you had any hormone laboratory tests? If so, what were the results?

_____

Has your partner had a fertility work-up? If so, what were the results?

_____

How often do you have intercourse? _____

Are you presently seeing a Fertility Doctor? _____ If so, name of Fertility Doctor and clinic _____

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