

健康

San Francisco Integrative Medicine
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Women's Fertility History

CONFIDENTIAL

Please list your doctor or fertility specialist _____

Please answer the following questions:

1. How long have you been trying to conceive? _____
2. Has your husband/partner had a fertility work up? Yes No
What were the results? _____
3. During which day of your cycle do you ovulate? _____
4. What method do you use to determine ovulation? _____
5. Do you have pain or cramping during ovulation? Yes No
6. Do you have to do a Clomid challenge test? _____ at day 3 _____ at day 10 _____
at _____ (month/year)
7. Have you done BBT testing? Yes No
8. How many D&C's have been performed? _____
9. Have you had fertility treatments? Yes No
10. How is your sexual energy? Low Normal High
11. Do you use vaginal lubricants? Yes No
12. Are you more than 20% below your ideal body weight? Yes No
13. Are you more than 20% over your ideal body weight? Yes No
14. Do you have oily skin? Yes No
15. Do you have excessive facial hair? Yes No
16. Have you been exposed to any known environmental toxins? Yes No
17. Have you taken oral contraceptives? Yes No
When? _____ How long? _____ What kind? _____
18. Have you had a diagnosis related to infertility? Yes No
What was it? _____

Please list all fertility treatments and pregnancies below:

Date	Natural, IUI, IVF, Other	Medications Used	# of Mature Eggs/Follicles	Pregnancy		If miscarried, indicate at which week
				Y	N	

Please check any that apply and enter the date diagnosed:

- High FSH _____ Low progesterone _____ POF _____

Please indicate if you have had any of these fertility tests or procedures and the date of the procedure:

- Laparoscopy _____ HSG – Hysterosalpingography _____ Other _____