





## Women's Fertility History *Continued*

Have you had fertility treatments?  Yes  No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

Have you taken medication to help you ovulate?  Yes  No

When \_\_\_\_\_ How long? \_\_\_\_\_

Have your fallopian tubes been evaluated medically?  Yes  No

What were the results? \_\_\_\_\_

Have you had any tubal operations?  Yes  No

Have you had any hormone laboratory tests performed?  Yes  No

What were the results? \_\_\_\_\_

Do you have a single partner with whom you have been trying to conceive?  Yes  No

How long have you been married or living together? \_\_\_\_\_

Has he had a fertility workup?  Yes  No

What were the results? \_\_\_\_\_

Is your partner supportive of your wish to conceive?  Yes  No

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  Yes  No

With what? \_\_\_\_\_

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 have excessive facial hair?  Yes  No

Do you have excessively oily skin?  Yes  No

Have you experienced excessive loss of head hair?  Yes  No

Have you noticed discharge from your nipples?  Yes  No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?  Yes  No

Have you been exposed to any known environmental toxins or hormones?  Yes  No

Are you presently taking steroids?  Yes  No

COMMENTS/NOTES