BALANCE
INTEGRATED HEALTHCARE

Date of initial Health Tx:

Update 1_____
2_____
3_____
4_____
5_____
6

Family Fertility Clinic -Female Fertility Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Patient's Name_____Gender: _____

Height:_____ Weight:_____ Birthdate:_____

Address:_____

PhoneNumber:(h)_____(w)_____(c)_____

Email Address _____

Are you under the care of a physician now? ___Y___N

If yes, for what? _____

Physician Name:_____ Tel:_____

In Emergency Notify:_____ Relationship:_____

Referred by:_____

Main Problem:

_____
_____
_____

Other Treatments:

_____
_____

Significant Illness:

_____
_____

Surgeries (list):

_____
_____

Allergies:
_____
_____

Major Trauma (car accident, fall, etc.)
_____
_____

Are you currently taking any medicine? ____Y ____N

Please list:_____

Are you currently taking any non-prescribed medicine (for i.e. herbs, vitamins, supplements, etc.)?
____Y ____N
Please list:_____

Occupational Stress (chemical, Physical, psychological):
_____

Exercise: _____

Daily diet: _____

Habits: (please circle) Cigarettes Alcohol Soft drinks Coffee Tea

Please describe or elaborate on the following questions:

Pain – _____

Appetite – _____

Thirsty –_____

Energy –_____

Sleep –
_____

Abnormal Sweating – _____

Skin and hair problems – _____

Bowel Movement – _____

Other digestive problems - _____

Urination –_____

Mood – _____

Headaches - _____

Pre-Menstrual

Do you have PMS? yes no
Does your face break out before or during your period? yes no
Do you get pre-menstrual low back pain? yes no
Do your bowel movements change before or during your period? yes no
Do you experience premenstrual headaches? yes no
Do your breasts become tender before your period? yes no

Menstruation

Age at which menses began:
Have your cycles changed since they began? yes no
How?
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
Are your menstrual cycles spaced irregularly? yes no
How many days are there from one period to the next?
Date of last menstrual period:

Pregnancy History

How many pregnancies have you had?
How many children do you have?
How many abortions have you had?
How many miscarriages have you had?
How many times has a D&C been performed?

Miscellaneous Questions

Do you bleed or spot between periods? yes no
Have you ever had an abnormal pap smear? yes no
Have you ever had a cervical biopsy, operation, cauterization or conization? yes no
Have you ever had a sexually transmitted disease (STD)? yes no
Have you ever been tested for STD's yes no
Do you get yeast infections regularly? yes no
Have you ever been diagnosed with a chlamydial infection? yes no
Do you have chronic vaginal discharge? yes no
Do you have any sores on your genitalia? yes no
Have you ever had pelvic inflammatory disease? yes no
Were you treated for this? yes no
How?
Date of last Pap smear
Have you ever been diagnosed with uterine fibroids or polyps? yes no
Have you ever been diagnosed with endometriosis? yes no
Have you been diagnosed with pelvic adhesions? yes no

Have you taken any medications for gynecological conditions other than birth control or for fertility?
If so, what were medications and reason for taking them and how long did you take them for?

Describe your libido or sex drive? low normal high
Do you douche regularly? yes no
With what?
Do you use vaginal lubricants? 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
Have you been exposed to any known environmental toxins or hormones? yes no

Fertility Treatment History

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
Have you ever taken oral contraceptives? yes no
When? How long?
Have you ever had an IUD? yes no
When? How long?
Have you ever taken other forms of hormonal birth control? yes no
When? How long?
How long have you been trying to conceive?
Have you had a diagnosis relating to infertility? yes no
What was it?

Signature_____ Date_____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.

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