FERTILITY ADDENDUM

Name _____ Date _____

Total pregnancies _____ Full term deliveries _____ Premature deliveries _____ Abortions _____ Miscarriages _____

How long have you been trying to conceive? _____

Been medically evaluated? Y / N If Y, what is infertility diagnosis? _____

Hormone labs performed? Y / N If Y, results _____

Fallopian tubes checked? Y / N If Y, results _____

Tubal ligations performed? Y / N If Y, results _____

Your partner been tested? Y / N If Y, results _____

List all therapies (IVF, IUI, Meds, Acupuncture, etc) you **HAVE** done, **ARE** doing, **INTEND** to do & with **WHO:**

_____

_____

_____

Check all that apply

☐ Excessive hair loss	☐ Excessive facial hair	☐ Excessively oily skin	☐ Thyroid problems
☐ Face breakout at cycle	☐ Tender breasts at ovulation	☐ Low sex drive	☐ Steroids
☐ Oral Contraceptives	☐ IUD	☐ Depo Provera Shot	☐ Diaphragm
☐ Nipple discharge	☐ Vaginal Discharge	☐ Yeast Infections	☐ Vaginal Lubricants
☐ Genitalia sores	☐ Venereal Disease	☐ Chlamydia	☐ Abnormal PAP
☐ Pelvic adhesions	☐ Pelvic Inflammatory Disease	☐ Uterine Polyps	☐ Uterine Fibroids
☐ Endometriosis	☐ Cervical Biopsy	☐ Cervical Operation(s)	☐ Cervical Conization
☐ PMS (back pain/cramps)	☐ PMS (mood swings)	☐ Painful Periods	☐ Spot between Periods
☐ Clotting	☐ Painful Intercourse	☐ Bleed after Intercourse	☐ Regularly douche

Are you getting your period? Y / N If N, when was last time? _____ If Y, how many days do you flow for? _____

Cycle Flow: Very Light / Light / Average / Heavy / Varies Typical Color of Blood: Black / Brown / Purple / Red / Light Red

Days between periods? _____ Are you ovulating? Y / N / Not Sure Cycle day you typically ovulate? _____

Age your menses began? _____ (not sure) What day of your cycle are you currently on? _____