Xu Wellness Center
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Women's Fertility Information

Name	Date	Age
Spouse's/Partner's Name	Occupation	
Doctor	Fertility Clinic	

How long have you been trying to conceive? _____

Have you been given a diagnosis relating to infertility? If yes, what was it? _____

_____

_____

_____

Are you currently undergoing fertility treatments? If yes, please list: _____

_____

_____

_____

Are you scheduled for an IUI or IVF procedure? If yes, when: _____

_____

Have you had IUI or IVF procedures in the past? If yes, when: _____

_____

Were these previous IUI or IVF procedures successful? _____

_____

Do you ovulate on your own? If yes, on what day of your cycle: _____

_____

Have you taken medications to help you ovulate? If yes, when and what types?

_____

Is there a history of infertility in your family? If yes, please explain: _____

_____

_____

Is there history of breast, uterine, ovarian or fallopian cancers in your family? If yes, please explain: _____

_____

Is there history of any genetic birth defects or mental retardation in your family? If yes, please explain: _____

_____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? _____

Have you ever been exposed to any environmental toxins? If yes, please explain: ____

_____

Have you conceived naturally in the past? If yes, when and was it with your current partner? _____

_____

How many children do you have? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

How many abortions have you had? _____

Has your spouse/ partner had a fertility workup? What were the results? _____

_____

Do you or your partner suffer from any sexual dysfunctions? If yes, please explain:

_____

How is your sexual energy? _____

_____

Do you have a healthy body weight? If no, please explain: _____

_____

Do you smoke? If yes, how much? _____

Do you have an unhealthy diet? If yes, please list the unhealthy foods and drinks that you consume regularly, along with the frequency: _____

_____

Do you consume soy products? If yes, how often: _____

_____

Do you use any recreational drugs? If yes, what and how often: _____

_____

Do you have cravings during or before menstruation? If yes, what do you crave?

_____

Are you stressed often? _____

Do you douche regularly? If yes, what do you use? _____

_____

Do you use vaginal lubricants? If yes, what do you use? _____

_____

Are you taking steroids? _____

Have you been diagnosed as perimenopausal or menopausal? _____

Age when menstruation began: _____

Have your cycles changed since they've begun? If yes, please explain: _____

_____

Are you taking any medications/ supplements/ herbs for gynecological conditions?

If yes, please list: _____

_____

_____

Please list all oral contraceptives you've taken, include the types and the dates:

_____

_____

Have you had a progesterone blood test? If yes, what were the results? _____

_____

Have you had a FSH blood test? If yes, what were the results? _____

_____

Have you had a thyroid test? If yes, what were the results? _____

_____

Have you had any hormone tests? If yes, what were the results? _____

_____

Have you had a glucose or insulin test? If yes, what were the results? _____

_____

Have you had a cervical biopsy, operation, cauterization, or conization? If yes, when:

_____

Have you had any other tests or procedures relating to fertility? If yes, please explain: _____

_____

Have you ever or do you presently suffer with any of the following:

☐ Recent Weight Loss/ Gain	☐ Fibroids	☐ Ovarian Cysts/ Tumors
☐ Endometriosis	☐ Polyps	☐ Scar Tissue in Pelvis/ Uterus
☐ Tubal Pregnancy/ Operations	☐ PID (Pelvic Inflammatory Disease)	☐ Thyroid Disease
☐ Adrenal Disease	☐ POF (Premature Ovarian Failure)	☐ PCOS (Polycystic Ovarian Disease)
☐ Diabetes	☐ Chlamydia	☐ HPV
☐ Gonorrhea	☐ Herpes	☐ Genital Warts
☐ Syphilis	☐ Other STD:	☐ Poor Response to Fertility Drugs
☐ Chromosomal Defect	☐ Hot Flashes	☐ Lupus
☐ Anemia/ Blood Disease	☐ Sickle Cell Anemia	☐ Chicken Pox

☐ Cystic Fibrosis	☐ HIV/ AIDS	☐ Luteal phase defect
☐ Spotting Before Period	☐ Dry Vagina	☐ Abnormal Pap Smear
☐ Excessive Facial Hair	☐ Regular Yeast Infections	☐ Adhesions