Trillium Natural Medicine, LLC
naturopathic medicine & acupuncture

3043 West Liberty Ave.
Pittsburgh, PA 15216
412.571.9355

FERTILITY HEALTH HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home): _____ (work): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: ❑ Female ❑ Male

Education: _____

❑ Married ❑Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Partnership

Live with: ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone

Occupation: _____ Hours per week: _____ ❑ Retired

Employer: _____

(Work address): _____

How did you hear about Trillium Natural Medicine? _____

Has any other family member already been a patient at Trillium Natural Medicine? _____

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

For the Following, Please Check the Appropriate Response Based on the Key Below:

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Menstrual History and Symptoms

Age of First Menses: _____ Are your cycles regular? ❑ Y ❑ N ❑ P Date of Last Menstrual Period _____

Length of cycle from one cycle to the next (days)? _____ How many days of bleeding during cycle? _____

How heavy is your menstrual bleeding? ❑ Light ❑ Normal ❑ Heavy

What color is the blood? ❑ Light Red ❑ Red ❑ Dark Red ❑ Purple ❑ Brown ❑ Black

Is there clotting with menses? ❑ Y ❑ N ❑ P Do you spot or bleed between menses? ❑ Y ❑ N

Cramping with menses? ❑ Y ❑ N ❑ P If yes, are they: ❑ Mild ❑ Moderate ❑ Severe

Have you ever missed school or work due to menstrual pain? ❑ Y ❑ N ❑ P

Treatment(s) for cramping: _____

Premenstrual Symptoms

Acne? ❑ Y ❑ N ❑ P Breast Tenderness? ❑ Y ❑ N ❑ P Cramping before menses? ❑ Y ❑ N ❑ P

Night sweats ❑ Y ❑ N ❑ P Emotional before menses? ❑ Y ❑ N ❑ P If yes, describe emotional state: _____

Ovulation Symptoms

How do you currently track your ovulation date? _____

Typical day of menstrual cycle that you ovulate? _____

Do you ovulate naturally? ❑ Y ❑ N ❑ P Do you have cervical mucus discharge at ovulation? ❑ Y ❑ N ❑ P

Medications & Contraception

Type of Oral Birth Control Currently Used: _____ Dose: _____ Length of Use: _____

Type of Birth Control(s) used in Past: ❑ Oral Birth Control ❑ IUD ❑ Depo Provera ❑ Condoms

❑ Diaphragm ❑ Foams / Jellies ❑ Withdrawal Method ❑ Rhythm Method ❑ Tubal Ligation

When did you last use contraception? _____

Contraceptive Complications: _____

Please list all other medication for gynecological conditions (not fertility related): _____

_____

_____

Reproductive Health History

Date of last PAP exam: _____ Abnormal PAP exam? ❑ Y ❑ N ❑ P If yes, when? _____

Number of Pregnancies: _____ Any complications with pregnancy?_____

Number of Live Births: _____ Number of Abortions: _____ Number of Miscarriages: _____

Have you ever had any of the following (check all that apply):

❑ Gonorrhea ❑ Venereal Warts ❑ Syphilis ❑ Chlamydia ❑ Genital Herpes ❑ Pelvic Inflammatory Disease (PID)

If yes, please explain the year and diagnosis and the treatment: _____

Have you ever been diagnosed with any of the following (check all that apply):

❑ Pelvic Adhesions ❑ Fibroids ❑ Pelvic Abnormalities ❑ Polyps

❑ Ovarian Cysts ❑ Endometriosis ❑ Yeast Infections ❑ Chronic Discharge

If yes, please explain the year and diagnosis and the treatment: _____

Date of last Mammogram:_____ Have you ever had an abnormal Mammogram? ❑ Y ❑ N Year: _____

If you have had an abnormal Mammogram, what was done about it?_____

Breast lumps or pain? ❑ Y ❑ N ❑ P Nipple discharge ❑ Y ❑ N ❑ P

Pregnancy Health History

**Outcomes: Vaginal Delivery = VD, Cesarean section = CS, Abortion = AB, Miscarriage = MS, Ectopic = EP*

1st Pregnancy When? (year) _____ How long to conceive? (months) _____ Fertility therapy used? ❑ Y ❑ N

Is current partner the father? ❑ Y ❑ N Duration of pregnancy? (months) _____ Outcome* _____

Complications _____

2nd Pregnancy When? (year) _____ How long to conceive? (months) _____ Fertility therapy used? ❑ Y ❑ N

Is current partner the father? ❑ Y ❑ N Duration of pregnancy? (months) _____ Outcome* _____

Complications _____

3rd Pregnancy When? (year) _____ How long to conceive? (months) _____ Fertility therapy used? ❑ Y ❑ N

Is current partner the father? ❑ Y ❑ N Duration of pregnancy? (months) _____ Outcome* _____

Complications _____

4th Pregnancy When? (year) _____ How long to conceive? (months) _____ Fertility therapy used? ❑ Y ❑ N

Is current partner the father? ❑ Y ❑ N Duration of pregnancy? (months) _____ Outcome* _____

Complications _____

5th Pregnancy When? (year) _____ How long to conceive? (months) _____ Fertility therapy used? ❑ Y ❑ N

Is current partner the father? ❑ Y ❑ N Duration of pregnancy? (months) _____ Outcome* _____

Complications _____

Fertility Health History

Have you had fertility treatments? ❑ Y ❑ N If yes, where and when?_____

Overseeing Physician _____

How long have you and your present partner been trying to conceive? _____

Have you ever been infertile with a past partner? ❑ Y ❑ N If so, how long? _____

Have you ever had any of the following tests performed on you? Check all that apply and the results.

Procedure	Date	Results
❑ Basal Body Temperature		
❑ Urinary LH (Ovulation) Predictor Kits		
❑ Postcoital Test		
❑ Hormone Tests		
❑ Endometrial Biopsy		
❑ Hysterosalpingogram (HSG)		
❑ Sonohysterogram		
❑ Ultrasound		
❑ Antisperm Antibodies		
❑ Laparoscopy		
❑ Hysteroscopy		
❑ Gonorrhea / Chlamydia Culture		
❑ Rubella (German Measles)		
❑ Hepatitis B or C		
❑ HIV		
❑ RPR (Syphilis)		
❑ 0 Blood Type and Rh		
❑ Antibody Screen		

What types of fertility therapy have you received in the past?

Drug / Treatment	Dose	How long or how many cycles?	When?
Clomiphene citrate (Clomid, Seraphene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Donor Insemination			
In Vitro Fertilization = ICSI			

Family Health History

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? ❑ Y ❑ N

Does any family member have significant health problems or inherited diseases? ❑ Y ❑ N

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? ❑ Y ❑ N

Check all that apply:

❑ Birth Defects	❑ Down Syndrome	❑ Muscular Dystrophy	❑ Brain / Spinal Defects	❑ Fragile X Syndrome
❑ Sickle Cell Disease	❑ Cancer	❑ Heart Disease	❑ Tay-Sachs Disease	❑ Cystic Fibrosis
❑ Hemophilia	❑ Thalassemia	❑ Diabetes	❑ High Blood Pressure	❑ Thyroid Disease

Who? _____

Are you from any of these ethnic backgrounds?

❑ Italian	❑ Jewish	❑ Caucasian	❑ African American	❑ Greek	❑ Filipino
❑ French Canadian	❑ African	❑ Middle Eastern	❑ Cajun	❑ Spanish	❑ Hispanic
❑ Southeast Asian	❑ Southern Chinese	❑ Asian Indian	❑ Taiwanese		

Thank you for your time and effort. We look forward to providing you with the best possible care.