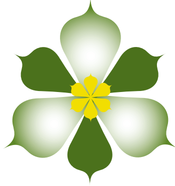

trillium
NATURAL MEDICINE
naturopathic medicine & acupuncture

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.