

# Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Fertility Clinic \_\_\_\_\_

Physician \_\_\_\_\_

## Western Medical Diagnosis (if any)

## Western Diagnostic Tests & Hormone Panels (include dates & results)

<input type="checkbox"/> Hysterosalpingogram (HSP)	_____
<input type="checkbox"/> Endometrial Biopsy	_____
<input type="checkbox"/> Clomid Challenge	_____
<input type="checkbox"/> Follicle Stim. Horm. (FSH)	_____
<input type="checkbox"/> Leutinizing Horm. (LH)	_____
<input type="checkbox"/> Estradiol	_____
<input type="checkbox"/> Progesterone	_____
<input type="checkbox"/> Prolactin	_____
<input type="checkbox"/> Any additional tests	_____
	_____

## GYN related surgeries (dates & outcome)

If past treatment has included any assisted reproductive technologies (ART), please indicate the procedures, dates, medications, your body's response (egg number, egg quality, number of cells, unwanted side effects, etc.), and the results. If additional space is needed, please use the back of the last page.

**Intrauterine Insemination (IUI)**

**In Vitro Fertilization (IVF)**

**Gamete Intrafallopian Transfer (GIFT) & Zygote Intrafallopian Transfer (ZIFT)**

**Male Factor**

<input type="checkbox"/> Sperm Count (#/cc)	_____
<input type="checkbox"/> Sperm Motility (% moving)	_____
<input type="checkbox"/> Sperm Morphology	_____

Please indicate any other forms of past treatment, both conventional and alternative.

**Other Past Treatments**

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If you have any other comments, concerns, or issues that you would like to discuss please do so below.

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