Fertility Treatment History
Center for Complementary Medicine Inc.
Lyn Swirda Lic.Ac., M.Ac., Dipl.Ac.

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)

☐ Hysterosalpingogram (HSP) _____

☐ Endometrial Biopsy _____

☐ Clomid Challenge _____

☐ Follicle Stim. Horm. (FSH) _____

☐ Leutinizing Horm. (LH) _____

☐ Estradiol _____

☐ Progesterone _____

☐ Prolactin _____

☐ 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

☐ Sperm Count (#/cc) _____

☐ Sperm Motility (% moving) _____

☐ Sperm Morphology _____

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

Other Past Treatments

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