Name: _____ Date: _____

Fertility Assessment Form

Couples Background Information

1. How long have you been trying to conceive? Has a semen analysis been performed? If so when?

_____

_____

2. Have you had any diagnostic testing to rule out anatomical causes of infertility *(male and female)*? If yes, then list when and what studies were performed.

_____

_____

3. Is there any history of infertlity in the family? If yes please provide more information.

_____

_____

4. Do you know of any potential causes of your infertility? If so please provide details.

_____

_____

5. Have you consulted with a fertility specialist? If so please provide details.

_____

_____

6. Have you had any ferlitly treatments ? If so please provide details.

_____

_____

Name: _____ Date: _____

Fertility Assessment Form

Female Section

1. Do you know when you mother tranisitioned into menopause?

_____

2. Do you have regular menstrual cycles? If yes please provide details.

_____

_____

3. Is there a history of any type of birth control? If yes please provide more details.

_____

_____

4. Is there any history of hormone replacement? If so please provide details.

_____

_____

5. Have you ever been diagonsed with polycystic ovarian syndrome? *(PCOS)* If so please provide details.

_____

_____

6. Have you ever been diagnosed with diabetes or pre-diabetes? If so please provide details.

_____

_____

7.Have you been diagnosed with endometriosis, uterine fibroids,cysts or begnign growths? If so please provide details.

_____

_____

Name: _____ Date: _____

Fertility Assessment Form

Female Section

1. Have you ever been diagnosed with cervical stenosis? If so please provide details.

_____

2. Have you ever been diagnosed with an autoimmune disease? If yes please please provide details if you or a family member have been diagnosed.

_____

_____

3. How would your rate your body mass? please check one

Normal ___ Underweight ___ Overweight ___

4. Have you ever had an STI or HIV? If so please provide details.

_____

_____

5. Have you ever been diagonsed with a pelvic inflammatory condition?If so please provide details.

_____

_____

6. Have you ever had any pelvic surgeries or procedures? If so please provide details.

_____

_____

7. Do you smoke/vape cigarettes or marijuana? Or taken illicit drugs? If so please provide details.

_____

_____

Fertility Assessment Form

Female Section

Please mark any medications that you currently use or have used in the past.

Medications:

__ Antihistamines
__ Cough suppressants
__ Atropine
__ Sinus congestion medications
__ Propantheline
__ Clomid
__ Steroids
__ Anti-neoplastic medications
__ Chemotherapy
__ Autoimmune medications
__Antidpressant medication
__ Epilepsy medication
__ Blood pressure medication
__ Cocaine
__ Hormones (estrogen, progesterone, testosterone)
__ Protonics- antacids
__ Motility Medications
__ Opioids
__ Antipsychotic medications
__ Hallucinogens

Circle 0=never, 1=sometimes,2=frequently, 3= most of the time

Endometriosis:

Do you experience painful menstrual cycles? 0 1 2 3
Do you experience pain with intercourse? 0 1 2 3
Do you experience pain with urination or bowel movement? 0 1 2 3
Do you experience abnormal menstrual bleeding? 0 1 2 3

Hyperlactinemia:

Do you ever experience a milky discharge from your nipples? 0 1 2 3
Do you ever experience vaginal dryness? 0 1 2 3
Do you experience pain with intercourse? 0 1 2 3
Do you have reduced sex drive? 0 1 2 3

Hypothyroidism:

Do you experience fatigue? 0 1 2 3
Do you experience reduced brain endurance? 0 1 2 3
Do you experience reduced muscle endurance? 0 1 2 3
Have you noticed hair thinning or hair loss? 0 1 2 3
Do you have difficulty regulating body temperature? 0 1 2 3

Name: _____ Date: _____

Fertility Assessment Form

Male Section

1. Do you have a history or hormome or testosterone replacement therapies? If so please provide details.

_____

2. Have you ever been diagnosed with andropause or endocrine disorder? If so please please provide

_____

_____

3. Have you ever been diagnosed with erectile dysfunction? If so please provide details.

_____

4. Have you ever beem diagnosed with a varicocele or testicular infection? If so please provide details.

_____

_____

5. Have you ever had any pelvic surgeries *(hernia,prostate,testicular, rectal*)? If so please provide details.

_____

_____

6. Have you ever been diagnosed with prostatis? If so please provide details.

_____

_____

7. Do you smoke/vape cigarettes or marijuana? Or taken illicit drugs? If so please provide details.

_____

_____

Name: _____ Date: _____

Fertility Assessment Form

Male Section

1. Have you ever been diagnosed with diabetes or pre-diabetes? If so please provide details.

_____

2. Do you have any penis deformities or an undescended testes? If so please please provide details.

_____

_____

3. Have you ever been diagnosed with an autoimmune disease? If so please provide details.

_____

4. How would your rate your body mass? please check one
__ Normal __ Underweight __ Overweight

_____

5. Have you ever been infected with an STI or HIV? If so please provide details.

_____

_____

6. Have you ever been diagnosed a pelvic inflammatory condition? If so please provide details.

_____

_____

7. Have you had any exposure to chemotherapy or radiation? If so please provide details.

_____

_____

Name: _____ Date: _____

Fertility Assessment Form

Male Section

1. Do you drink alcohol? If so please provide details.

_____

2. Do you consume caffeine? If so please please provide details.

_____

_____

3. Do you exercise? If so please provide details.

_____

Circle 0=never, 1=sometimes,2=frequently, 3= most of the time

Hyperlactinemia:

Do you ever experience a milky discharge from your nipples?	0 1 2 3
Do you ever experience vaginal dryness?	0 1 2 3
Do you experience pain with intercourse?	0 1 2 3
Do you have reduced sex drive?	0 1 2 3

Hypothyroidism:

Do you experience fatigue?	0 1 2 3
Do you experience reduced brain endurance?	0 1 2 3
Do you experience reduced muscle endurance?	0 1 2 3
Have you noticed hair thinning or hair loss?	0 1 2 3
Do you have difficulty regulating body temperature?	0 1 2 3

_____

Name: _____ Date: _____

Fertility Assessment Form

Andropause:

Reduced muscle endurance	0 1 2 3
Reduced sexual endurance?	0 1 2 3
Reduced muscle mass	0 1 2 3
Reduced motivation and drive	0 1 2 3

Please mark any medications that you currently use or have used in the past.

Medications:

__ Ulcer medications
__ Steroids
__ Chemotherapy
__ Antineoplastic medications
__ Seizure medications
__ Antidepressants
__ Antifungal medications
__ Calcium channel blockers
__ Psoriasis medications