

Setareh Tais, ND

Phone: 559-470-3435

Female Infertility Profile:

Name: _____

Date: _____

Many women will have decreased fertility for unknown reasons. By completing the following comprehensive questionnaire, you will help us identify factors that may influence your health and fertility. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so.

Female fertility history

How many months have you been trying to achieve pregnancy with your current partner? _____

Have you ever achieved pregnancy in the past? yes no

If yes, with current partner previous partner

Years of all previous pregnancies _____ Not applicable

Outcome of pregnancy: Not applicable

Uncomplicated vaginal delivery Cesarean section Miscarriage Elective abortion

Ectopic pregnancy Premature birth Stillbirth Birth defects Other: _____

Has anyone in your family experienced problems with fertility? Yes No

If yes, explain: _____

Have you been evaluated for infertility? yes no

If yes, name of Physician: _____ Year of evaluation: _____

What tests were performed? Pelvic ultrasound Hysterosalpingogram Laparoscopy

Basal body temperature Urinary ovulation test Cervical mucus testing Endometrial biopsy Blood tests: _____ I don't know

What diagnosis were you given? Irregular ovulation Blocked fallopian tubes

Endometriosis Uterine fibroids Abnormal cervical mucus or opening Autoimmune disease Blood clotting disease Fertile or unexplained infertility Other

Are you currently receiving or planning to receive infertility treatment? No Antibiotics Hormones

Ovulation induction Surgery Intrauterine insemination In vitro fertilization

With your current partner, how many months have you used contraception prior to trying to conceive: _____

What has been your most recent form of contraception: _____

Methods used in the past: _____

Do you have any non-fertility related health problems? yes no

If yes, explain: _____

Sexual history

Do you have problems with sexual desire? yes no

Do you use lubrication with intercourse? yes no

Have you ever had white, green or yellow vaginal discharge? yes no

Do you have pain with intercourse? yes no

Have you ever had a urinary tract infection? yes no

Have you ever had problems with recurrent vaginal infections? yes no

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Have you or your partner had any of the following diseases? () herpes () pelvic inflammatory disease (PID)
 () gonorrhea () chlamydia () urethritis () syphilis () HIV () genital warts/HPV () none

Family and Genetic History

Please answer the following medical history questions about yourself, your partner and your relatives. Please consider all family members related to you or your partner by blood. Consider parents, siblings, half-siblings, grandparents, aunts, uncles, nieces, nephews, cousins and children you have had.

Check “yes” if the condition has occurred in you, your partner and/or any of your relatives. Additional space is provided below.	Female and her family		Male and his family	
	Yes <input type="checkbox"/>	Who?	Yes <input type="checkbox"/>	Who?
Open spine defects (spina bifida, anencephaly)				
Heart defect				
Cleft lip and/or palate				
Other birth defects				
Chromosome condition (Down’s syndrome, translocation carrier)				
Blood disorder (sickle cell anemia, thalassemia, hemochromatosis)				
Bleeding disorder (hemophilia)				
Cystic fibrosis				
Other inherited or genetic condition				
Cancer (before age 50 years)				
Three or more miscarriages				
Stillborn baby or baby that died within the first year				
Premature menopause				
Infertility				
Other				

For any of the above answered “yes”, please specify the condition?

Are you and your partner related by blood? () yes () no

If yes, how are you related? _____

Ethnicity

Are you of Caucasian ancestry? () yes () no

If yes, have you been tested as a carrier of cystic fibrosis? () yes () no Results: () carrier () non-carrier

Are you of French Canadian ancestry? () yes () no

If yes, have you been tested for Tay Sachs disease? () yes () no Results: () carrier () non-carrier

Are you of Jewish ancestry? () yes () no

If yes, have you been tested as a carrier for () Tay Sachs disease () Gaucher’s disease () Nieman-Pick
 () Canavan’s disease () Fanconi anemia () Bloom syndrome () Dysautonomia

Results: () non-carrier () carrier of _____

Are you of Black ancestry? () yes () no

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If yes, have you been tested for sickle cell disease? () yes () no Results: () carrier () non-carrier
 Are you of Caribbean, Mexican, or Central American ancestry? () yes () no
 If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier
 Are you of Greek, Italian or Middle Eastern ancestry? () yes () no
 If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier
 Are you of Asian ancestry? () yes () no
 If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier

Menstrual history

Age at first period? _____ First day of last period? _____
 Are your periods regular? () yes () no
 If yes, what is the usual number of days between periods? _____
 If no, how many times a year do you menstruate? _____
 Do you have pain or cramps with your period? () yes () no
 What is your usual duration of your period? _____ () Heavy () Moderate () Light
 Use: () Tampons () Pads
 Do you bleed or spot between periods? () yes () no
 Do you have pain when you ovulate? () yes () no
 Date of last Pap smear? _____ () Normal () Abnormal: _____
 Do you have a history of abnormal paps? () yes () no
 If yes, please specify; include date and treatment: _____
 Please list any premenstrual symptoms you experience: _____

Pregnancy history

	Year	Outcome: Live birth? Loss?	How long to conceive?	Infertility treatment needed?	Gest age at time of loss or delivery	Infant sex/name	Complications with mom	Complications with baby
1								
2								
3								
4								
5								
6								

Notes: _____

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General medical history

Have you lost or gained more than 15 pounds this year? no yes: _____

Do you have or have you ever had (check all that apply):

- Thyroid problems Milky breast discharge Breast soreness Abnormal hair growth
- Endometriosis Ovarian cysts Uterine fibroids Blood transfusion High blood pressure
- Diabetes or high blood sugar Depression or suicide attempt Anxiety

Have you ever had German measles (Rubella) or received the vaccine? yes no

If yes, please specify including date: _____

Have you had chicken pox (varicella) or Fifth disease (parvovirus)? yes no I don't know

Please list all medical procedures and surgeries including D&Cs, colposcopies and LEEP procedures:

Procedure	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Partner's history (If your current partner is not a patient in our fertility program, please complete this section)

What is his age: _____

Has he ever achieved pregnancy in the past? yes no

If yes, with with you previous partner

Years of all previous pregnancies _____ Not applicable

Outcome of pregnancy: Not applicable

Healthy live birth Miscarriage Elective abortion

Ectopic pregnancy Premature birth Stillbirth Birth defects Other: _____

Has anyone in his family experienced problems with fertility? Yes No

If yes, explain: _____

Has he been evaluated for infertility? yes no

If yes, name of Physician: _____ Year of evaluation: _____

If yes, what tests were performed? Regular blood work Sperm analysis Other: _____

Findings/Treatment: _____

Social history

Do you smoke tobacco? yes no If yes, specify how much/often: _____

Do you drink alcoholic beverages? yes no If yes, specify type/amount/frequency: _____

Do you use recreational drugs? yes no If yes, specify type/amount/frequency: _____

At work are you exposed to: pesticides radiation industrial solvents plastics other

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Your personal philosophy

Have you and your partner discussed the level of intervention you are willing to try to have a baby? () yes () no and we have decided to consider...

- () Natural Interventions only
- () Natural Interventions plus safe, more gentle medications
- () A trial of natural interventions, then IVF and other conventional procedures if necessary
- () If not able to have biological children, that's ok, at least we tried
- () If not able to have biological children, we would love to adopt
- () Other conclusions: _____

Anything else about you that I should know?

Any specific questions you have?