



Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When _____ How long? _____

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

Do you have a single partner
with whom you have been trying to conceive? Yes No

How long have you been married or living together? _____

Has he had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

Was your mother exposed to
diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any
known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

COMMENTS/NOTES