East Wing

Fertility Intake Form

Describe your menstrual flow:
◯ Heavy ◯ Moderate ◯ Light ◯ None

Color of menstrual flow:
◯ Dark/purple ◯ Bright red ◯ Pale red/pink ◯ Brown

Do you have Clotting? If yes:
◯ Black/brown ◯ Red ◯ Dried blood ◯ Phlegm

How many days do you bleed? _____ How many days of spotting? _____

Do you have Cramping? If yes:
◯ Low back ◯ Abdominal ◯ Down legs

When do you feel them?
◯ Before period ◯ During period ◯ During ovulation

Is your entire cycle:
◯ Regular (# days between periods: _____) ◯ Irregular

PMS:
Breast tenderness ◯
Loose stool ◯
Fatigue ◯
Acne ◯
Irritability ◯
Depression ◯
Constipation ◯
Low back pain ◯
Bloating/water retention ◯
Migraines ◯

Do you have a history of: (circle all that apply)

Amenorrhea Ovarian cysts Failure to ovulate

Pelvic Inflammatory Disease Endometriosis Low libido

Painful intercourse Uterine fibroids Chronic vaginal or yeast infections

Fertility History

How long have you been trying to conceive? _____

Do you have a partner supportive of your journey? _____

Previous experience:

Pregnancies _____
Births _____
#Miscarriages _____
#Terminations _____

Have you had fertility treatments? ⬭ Yes ⬭ No Type _____

If you are undergoing ART now, which doctor/clinic are you seeing?

_____

Have you had a diagnosis related to fertility? ⬭ Yes ⬭ No / Unexplained

Western Diagnosis: _____

Relevant hormone lab values, if known: _____

Procedures done to diagnose or prepare for treatment _____

Do you chart ovulation with BBT charts or a kit? _____

Do notice cervical mucus at ovulation time? _____