healom ARTIFICIAL REPRODUCTIVE THERAPIES HISTORY

Name (Last, First, Middle)	Today's Date

Are you currently seeing an infertility specialist? ❑ Yes ❑ No

What type and practitioner name? _____

_____

Have you had a diagnosis relating to infertility? ❑ Yes ❑ No

What was it? _____

_____

_____

_____

_____

_____

Has your partner had a fertility workup? ❑ Yes ❑ No

Has your partner had a diagnosis relating to infertility? ❑ Yes ❑ No

What was it? _____

_____

_____

_____

_____

_____

Have you had fertility treatments? ❑ Yes ❑ No

If yes, when and where? _____

_____

_____

By whom? _____

_____

_____

What types? _____

_____

_____

_____

_____

_____

Medications for gynecological conditions other than contraceptives?

Medication	Reason	When

Are you > 20% over your ideal body weight? ❑ Yes ❑ No

Are you > 20% below your ideal body weight? ❑ Yes ❑ No

Do you have a stressful occupation? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No

Do you feel you have enough emotional support? ❑ 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

Additional Information

Email completed form to gina@healom.com.