# Fertility Assessment Form

Name of Female _____ Age of Female _____
Name of Male _____ Age of Male _____

## General Background (Couples Section)

How long have you been trying to conceive?_____

Has semen analysis been performed? ☐ No ☐ Yes
If yes, please provide the dates and findings.
_____
_____

Have there been any diagnostic imaging studies to identify any anatomical mechanisms for infertility (male and female)? ☐ No ☐ Yes
If yes, please list the studies and dates.
_____
_____

Is there any family history of infertility? ☐ No ☐ Yes
If yes, please provide details.
_____
_____

Do you know of or suspect any causes for your couple's infertility? ☐ No ☐ Yes
If yes, please provide details.
_____
_____

Have you consulted with a fertility specialist? ☐ No ☐ Yes
If yes, please provide details.
_____
_____

Have you conducted any fertility treatments? ☐ No ☐ Yes
If yes, please provide details.
_____
_____

## Female Section

**Female Causes and Risk Factors**

Do you know at what age your mother transitioned into menopause?_____

Do you have regular menstrual cycles? ☐ No ☐ Yes
If no, please explain.

_____
_____

Any history of oral contraceptives? ☐ No ☐ Yes
If yes, please provide dates and details.

_____
_____

An history of hormone replacement therapies? ☐ No ☐ Yes
If yes, please provide the dates and type of replacement.

_____
_____

Have you ever been diagnosed with polycystic ovarian syndrome (PCOS)? ☐ No ☐ Yes
If yes, please provide dates and details.

_____
_____

Have you ever been diagnosed with pre-diabetes or diabetes? ☐ No ☐ Yes
If yes, please provide dates and details.

_____
_____

Have you ever been diagnosed with endometriosis? ☐ No ☐ Yes
If yes, please provide dates and details.

_____
_____

Have you ever been diagnosed with uterine fibroids, cysts, or any benign growths?
☐ No ☐ Yes If yes, please provide dates and details.

_____
_____

Have you ever been diagnosed with cervical stenosis? ☐ No ☐ Yes
If yes, please provide dates and details.

_____

_____

Have you ever been diagnosed with an autoimmune disease? ☐ No ☐ Yes
If yes, please provide dates and details.

_____

_____

Do you have a family history of autoimmune disease? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

How would you rate your body mass? (please check one):
☐ normal ☐ underweight ☐ overweight

Have you ever been infected with chlamydia, gonorrhea, or HIV? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you ever been diagnosed with a pelvic inflammatory condition? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you had any pelvic organ surgeries or procedures? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you smoke cigarettes or marijuana? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you ever taken illicit drugs? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you had any known exposure to toxic chemicals? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you had any known exposure to air or water pollutants? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you had any exposure to chemotherapy or radiation? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you drink alcohol? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you consume caffeine? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you exercise? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

**PCOS Symptoms**
(Circle : 0=never, 1= sometimes, 2=frequently, 3= most of the time)

| | |
|---|---|
| Do you have excess or unwanted facial or body hair? | 0 1 2 3 |
| Do you experience scalp hair loss or hair thinning? | 0 1 2 3 |
| Do you have acne? | 0 1 2 3 |
| Do you experience absent, infrequent, or irregular menstrual cycles? | 0 1 2 3 |
| Do you experience fatigue and sugar cravings after meals? | 0 1 2 3 |
| Do you feel drops in energy in the afternoon? | 0 1 2 3 |
| Have you noticed increased weight gain and difficulty losing weight? | 0 1 2 3 |

**Endometriosis**

| | |
|---|---|
| Do you experience painful periods (pelvic pain and cramping) before and/or several days into your menstrual cycle? | 0 1 2 3 |
| Do you experience pain with intercourse? | 0 1 2 3 |
| Do you experience pain with bowel movements or urination? | 0 1 2 3 |
| Do you experience abnormal menstruation or spotting? | 0 1 2 3 |

**Hyperprolactinemia (Female)**

| | |
|---|---|
| Do you ever experience a milky discharge from your nipples? | 0 1 2 3 |
| Do you experience vaginal dryness? | 0 1 2 3 |
| Do you experience pain with intercourse? | 0 1 2 3 |
| Do you have a 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 your body temperature? | 0 1 2 3 |

## Medications That May Impact Female Fertility

Please mark any of the following medications that you currently use or have used in the past:

**Medications Impacting Ovarian Egg Quality or Quantity**

- ☐ Anti-neoplastic medications
- ☐ Chemotherapy
- ☐ Autoimmune Medications
- ☐ Steroids

**Medications Impacting Healthy Cervical Mucus**

- ☐ Antihistamines
- ☐ Cough suppressants
- ☐ Atropine
- ☐ Sinus congestion medications
- ☐ Propantheline
- ☐ Clomid

- ☐ Antidepressants
- ☐ Epilepsy drugs

**Medications that Impact Ovulation and Menstrual Cycle Factors**

- ☐ Antihypertensives
- ☐ Antipsychotics
- ☐ Cocaine
- ☐ Estrogens
- ☐ Anti-ulcer medication (cimetidine)
- ☐ Intestinal motility medication (metoclopramide)
- ☐ Hallucinogens
- ☐ Opioids
- ☐ Tricyclic antidepressants

## Male Section

**Male Causes and Risk Factors**

An history of hormone or testosterone replacement therapies? ☐ No ☐ Yes
If yes, please provide details.

Have you ever been diagnosed with andropause or endocrine disorders? ☐ No ☐ Yes
If yes, please provide details.

Have you ever been diagnosed with erectile dysfunction? ☐ No ☐ Yes
If yes, please provide details.

Have you ever been diagnosed with a varicocele or testicular infection? ☐ No ☐ Yes
If yes, please provide details.

Have you had any pelvic surgeries (inguinal hernia, prostate, scrotal, testicular, and/or rectal?)
☐ No ☐ Yes
If yes, please provide details.

Have you ever been diagnosed with prostatitis? ☐ No ☐ Yes
If yes, please provide details.

Have you ever been diagnosed with an autoimmune disease? ☐ No ☐ Yes
If yes, please provide details.

Do you have a family history of autoimmune disease? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you ever been diagnosed with pre-diabetes or diabetes? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you have any penis deformities or an undescended testis? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

How would you rate your body mass (please check one):
☐ normal ☐ underweight ☐ overweight

Have you ever been infected with chlamydia, gonorrhea, or HIV? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you ever been diagnosed with a pelvic inflammatory condition? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you smoke cigarettes or marijuana? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you ever taken illicit drugs? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Have you had any exposure to chemotherapy or radiation? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you drink alcohol? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you consume caffeine? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

Do you exercise? ☐ No ☐ Yes
If yes, please provide details.

_____

_____

**Andropause**
(Circle: 0=never, 1= sometimes, 2=frequently, 3= most of the time)

| | |
|---|---|
| Reduced muscle endurance and ability to exercise aggressively | 0 1 2 3 |
| Reduced sexual endurance | 0 1 2 3 |
| Loss of muscle mass | 0 1 2 3 |
| Reduced motivation and drive | 0 1 2 3 |

**Hyperprolactinemia (Male)**

| | |
|---|---|
| Do you ever experience a milky discharge from your nipple? | 0 1 2 3 |
| Have your nipples or breasts area become more round-shaped? | 0 1 2 3 |
| Do you experience low sex drive? | 0 1 2 3 |
| Do you experience difficulty maintaining an erection? | 0 1 2 3 |
| Do you experience difficulty getting an erection? | 0 1 2 3 |
| Is your libido reduced? | 0 1 2 3 |

**Erectile Dysfunction**

| | |
|---|---|
| Do you have trouble getting an erection? | 0 1 2 3 |
| Do you have trouble keeping an erection? | 0 1 2 3 |
| Do you take any medications or natural products to improve your erection? | 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 your body temperature? | 0 1 2 3 |

**Medications That May Impact Male Fertility**

Please mark any of the following medications that you currently use or have used in the past:

**Medications Impacting Sperm Quality and Quantity**

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