ilumina:
A peaceful path to pregnancy and healing

Female Fertility Form

CONFIDENTIAL

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Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Date of Birth _____ / _____ / _____	Age:	Stress Levels:	Height:	Weight:	Activity levels:	Occupation:

LMP: ______________________ Cycle Duration ________________

RE & I Clinic / Fertility Specialist:
Other OBGYN doctor ______________________________ Start Date: __________ Month/ Year

. Western Diagnosis ____

1. Fertility treatments (including cancelled cycles):

Date	Unassisted, IUI, IVF, FET	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

2. Diagnostics / Date

Elevated FSH	Elevated Prolactin	Endometriosis / Adhesions	PCOS/ Ovarian cysts	POF	Low Progesterone Level	Fallopian Tube Occlusion	STD's	Uterine Fibroids / Polyps

Others:____

3. Are you taking any of these medications and for how long?

Bromocriptine	Metformin	Baby Asprin	Other Medications

4. Female Health:

PID	Chlamydia	STD's	Herpes	Antisperm Antibodies	Others

5. Procedures performed / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

6. Lab Results/ Dates

FSH Level Day 3	E2 Day3	LH Day3	CCCT Day 10 FSH	P4 Day 21	Prolactin	HCG	Others & Thyroid

7. Lab Results on File Y / N

8. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

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9. Planned ART / Date:

IUI w/ Injectables	IUI w/ Oral Meds	Clomid/ Femara	IVF	PGD	Other

10. Fertility History / Dates

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

11. Other:

Age at which menses began? ___________
OCP ___________ How long? ___________
List name of birth control ______________________________________
How long TTC? _______________________
Clomid challenge test? _____________________ Date:_____________
Day 3______ at Day 10______ at ____________(month/year)
Recurrent yeast infections? _________ How often? __________

Natural Ovulation …………. Y / N
Which day of your cycle ______ to ______
Typically, how many days are there from one period to the next _____ to _____ days?
Today is which day of cycle? ________
Current month treatment plan _____________
(Natural, IUI, IVF, Any Tests, etc.)

9. PMS

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

10. Menstrual History

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

11. Is partner currently being treated by us? **Y / N**

12. Partner's Name ____

13. Western Diagnosis of the partner: ____

14. Do we have copies of labs / sperm analysis **Y / N**

15. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

16. Male Reproductive History/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / DNA	Anti- Sperm Antibodies	Others

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17. Following Fertility:

Basal Body Temperature Chart Y / N
Timed Sex …………………… Y / N
Stress Reduction ……………… Y / N
Diet Principals :
- ☐ Yin
- ☐ Yang
- ☐ Blood
- ☐ Qi

Ovulation

LH Sticks ……………………… Y / N
OPK …………………………… Y / N
Relationship / Sex …………….. Y / N

Avoid Ice cold Foods………... Y / N
Avoid Tampons……………… Y / N
Femoral Massage …………… Y / N
Visualization…………………. Y / N
Meditation …………………... Y / N
Yoga …………………………. Y / N
Qi Gong………………………. Y / N
Deep Breathing……………… Y / N
Journaling……………………. Y / N
Foot Soaks…………………… Y / N
Feminine Hygiene…………… Y / N
Detox……………………….... Y / N
Type of Detox
Feng Shui…………………….. Y / N

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