

## FERTILITY HEALTH HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Spouse/Partner Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Length of Marriage/Relationship: \_\_\_\_\_

1. Name & phone number of your medical doctor:

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2. Name & phone number of other health care providers working with you during infertility related problems:

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3. Briefly summarize your infertility history:

- ✓ Length of infertility struggles
- ✓ Diagnosis
- ✓ Number of Pregnancies (if any)
- ✓ Kind of pregnancy losses

4. Please list the number of attempts of assisted reproductive technology (if any) and results:

5. Names and ages of current children, if any:

6. Current procedures scheduled (or to schedule soon):

