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):

   _____
   _____
   _____
   _____

7. Have you considered any other fertility options to create your family?

_____

_____

8. Do you have any marital issues that you would like to address?

_____

_____

9. How *emotionally difficult* is your experience with infertility?

Scale: 0= Not Difficult 3= Somewhat Difficult 6= Very Difficult

- Depression ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6
- Anxiety ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6
- Other ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

10. Tell me about your support system.

_____

_____

11. In what ways do you handle stress?

_____

_____

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