Root & Branch Oriental Medicine
Fertility Treatment History

Please take the time to fill out this history as carefully and completely as possible, including dates, test results, and side effects. The more information we have the better able we are to provide the best possible treatment for your individual case.

Name:________________________________Age:_______Date:___________
Fertility Clinic:____
Physician:____

Western Medical Diagnosis (if any):

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Western Diagnostic Tests & Hormone Panels: (include dates and results)

Hysterosalpingogram (HSP)____
Endometrial Biopsy: ____
Clomid Challenge: ____
Follicle Stim Hormone: FSH____
Leutinizing Hormone: LH ____
Estradiol: ____
Progesterone: ____
Prolactin: ____
Any Additional Tests: ____

GYN Related Surgeries: (dates and outcomes)

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Male Partner Information:

Was there any screening tests done on your partner? Y / N
Is your partner currently, or willing to consider, being treated? Y / N
Please note if there was any problems indicated for the following:
Sperm Morphology____
Sperm Motility____
Sperm Count____

Is there any problem with any of the following:

Erectile Dysfunction____

Inability to Reach Orgasm____

Poor Sexual Drive____

If past treatment included any assisted reproductive treatments, please indicate the procedure, dates, medications, side effects, quality and quantity of eggs produced, size of eggs (number of cells), and the results.

IUI:____

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IVF:____

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Gamete Intrafallopian Transfer(GIFT) & Zygote Intrafallopian Transfer(ZIFT):

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Please indicate if you have tried any other treatments for this condition, both conventional and alternative:____

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