Guidelines for scheduling preconception appointments for Dr. Bathgate:

1. Please urge new patients to come early to fill out paperwork and verify insurance.
2. The patient’s partner is invited and encouraged to come to the appointment.
3. The woman and her partner should both fill out the preconception questionnaires and bring these completed questionnaires with them to their appointment.
4. If they have any specific medical questions about past conditions, if possible please have them bring copies of any medical records or tests that they might have.
5. A physical exam is not part of the preconception visit. If they are in need of an annual exam or have a specific physical problem requiring an examination, they should schedule a separate visit for this.
6. Please mail or fax a set of one female and one male preconception questionnaires to the patient at the time she makes the appointment.
7. Encourage the couple to notify our office in advance of her appointment if she has not received the questionnaires.

Thank you.
Dear Patient,

Thank you for scheduling an appointment with me for preconception counseling. My interest in helping couples prepare for pregnancy comes from my work with complicated and high risk pregnancies. My goal is to identify and help modify risk factors for poor pregnancy outcome before pregnancy whenever possible. To make the most out of your appointment, I would like you and your partner to complete the enclosed questionnaires before your appointment, and bring them with you to your visit. If you have particular medical questions about past or current medical conditions, please bring any copies of medical records and results of tests that you may have. I look forward to seeing you at your upcoming appointment.

Sincerely,

Susanne L. Bathgate, MD
Assistant Professor
Division of Maternal-Fetal Medicine
INTRODUCTION

The Pre-Conception Program of the Department of Obstetrics & Gynecology and the Center for Integrative Medicine at George Washington University Medical Center is a clinical program designed to optimize your obstetrical potential. We believe that by putting you in an optimal health – *physical, emotional and social* – environment, you will achieve the best possible obstetrical outcome. This may mean the reduction or prevention of miscarriages and other pregnancy related complications. If you have difficulty in conceiving, the program may enhance the results of your fertility treatments.

This program is based on the sound principle of prevention and supported by the result of the *Foresight Program* of the University of Surrey, England (web address), which was established in 1990. This is a six month program starting with two months of testing, diagnosis and planning followed by four months of implementation of the treatment plan, prior to any effort to conceive. It is rigorous and demands your and your partner’s commitment and active participation in every phase of the program. We will provide tools, guidance and encouragement and you have to do the work.

The first step is to fill out the enclosed questionnaire. This is your complete health inventory and forms the basis of our management plan. It is therefore important that you fill this out to the best of your ability. We will address any questions and concerns at the initial interview. This is part of your confidential medical record and will not be shared with anyone other than direct caregivers without your expressed permission.

We are privileged to be your healthcare partners and we are committed to do our best to help you reach your healthcare goals.

Susanne Bathgate MD
Assistant Professor
Medical Director – Pre-Conception Program
Department of Obstetrics & Gynecology

John Pan MD
Clinical Professor
Director
Center for Integrative Medicine
MALE QUESTIONNAIRE

PATIENT INFORMATION

Name __________________________________________
Spouse/Partner’s Name_____________________________
Address _________________________________________
_______________________________________________ zip______________
Tel: Home ________________Work___________________
Fax______________________E-Mail__________________
Date of Birth ___________________________Age_______
Education _______________________________________
Occupation _______________________________________

***********
Were you referred by another healthcare professional? If so, by whom were you referred?

What do you hope to achieve by participating in this preconception program?

What are your goals?
FEMALE QUESTIONNAIRE

PATIENT INFORMATION

Name __________________________________________
Spouse/Partner’s Name_____________________________
Address _________________________________________
_____________________________________________ zip____________
Tel: Home ________________Work___________________
Fax______________________E-Mail__________________
Date of Birth ___________________________Age_______
Education _______________________________________
Occupation ______________________________________

************

Were you referred by another healthcare professional? If so, by whom were you referred?

What do you hope to achieve by participating in this preconception program?

What are your goals?
MEDICAL HISTORY

**Past Medical Illnesses:** (Check diseases/conditions that apply to you. Indicate date if in the past.)

Please use the bottom or reverse side of the page to elaborate if necessary.

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Now</th>
<th>Past/Date</th>
<th>Disease/Condition</th>
<th>Now</th>
<th>Past/Date</th>
<th>Disease/Condition</th>
<th>Now</th>
<th>Past/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Cystic Acne</td>
<td></td>
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<tr>
<td>German Measles</td>
<td></td>
<td></td>
<td>Stomach Ulcers</td>
<td></td>
<td></td>
<td>Psoriasis</td>
<td></td>
<td></td>
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<tr>
<td>Measles</td>
<td></td>
<td></td>
<td>Colitis</td>
<td></td>
<td></td>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td>Hiatal Hernia</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>Polio</td>
<td></td>
<td></td>
<td>Irritable Bowel</td>
<td></td>
<td></td>
<td>Hayfever</td>
<td></td>
<td></td>
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<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td>Gallbladder Disease</td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td></td>
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<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td></td>
<td>Hypertension</td>
<td></td>
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<tr>
<td>CMV virus</td>
<td></td>
<td></td>
<td>Jaundice</td>
<td></td>
<td></td>
<td>Reynaud’s Syndrome</td>
<td></td>
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<tr>
<td>HIV virus (AIDS)</td>
<td></td>
<td></td>
<td>Bladder infection</td>
<td></td>
<td></td>
<td>SLE (Lupus)</td>
<td></td>
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<tr>
<td>Lyme Disease</td>
<td></td>
<td></td>
<td>Kidney infection</td>
<td></td>
<td></td>
<td>Thyroid Disease</td>
<td></td>
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<tr>
<td>Menigitis</td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td>Depression/Axiety</td>
<td></td>
<td></td>
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<tr>
<td>Tension headaches</td>
<td></td>
<td></td>
<td>Bursitis/Tendonitis</td>
<td></td>
<td></td>
<td>Anorexia</td>
<td></td>
<td></td>
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<tr>
<td>Migraine headaches</td>
<td></td>
<td></td>
<td>Gout</td>
<td></td>
<td></td>
<td>Bulimia</td>
<td></td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td>Osteoarthritis</td>
<td></td>
<td></td>
<td>Alcohol problem</td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Rheumatoid Arthritis</td>
<td></td>
<td></td>
<td>Drug problem</td>
<td></td>
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<tr>
<td>Pleurisy</td>
<td></td>
<td></td>
<td>Eczema</td>
<td></td>
<td></td>
<td>Food/Drug/Chemical Poisoning</td>
<td></td>
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<tr>
<td>Pneumonia</td>
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</tr>
</tbody>
</table>

**Review of Symptoms:** (Check symptoms that apply to you)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>now</th>
<th>past</th>
<th>Symptoms</th>
<th>now</th>
<th>past</th>
<th>Symptoms</th>
<th>now</th>
<th>past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back/Leg pain</td>
<td></td>
<td></td>
<td>Strange odor/taste</td>
<td></td>
<td></td>
<td>Blood in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Shoulder/Arm Pain</td>
<td></td>
<td></td>
<td>Persistent hoarseness</td>
<td></td>
<td></td>
<td>Burning on urination</td>
<td></td>
<td></td>
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<tr>
<td>Joint stiffness</td>
<td></td>
<td></td>
<td>Difficulty Swallowing</td>
<td></td>
<td></td>
<td>Swollen legs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint pain</td>
<td></td>
<td></td>
<td>Mouth dryness</td>
<td></td>
<td></td>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint swelling</td>
<td></td>
<td></td>
<td>Mouth tightness</td>
<td></td>
<td></td>
<td>General weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint redness/heat</td>
<td></td>
<td></td>
<td>Mouth sores</td>
<td></td>
<td></td>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness</td>
<td></td>
<td></td>
<td>Chronic cough</td>
<td></td>
<td></td>
<td>Chills</td>
<td></td>
<td></td>
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<tr>
<td>Fainting spells</td>
<td></td>
<td></td>
<td>Chest Pain</td>
<td></td>
<td></td>
<td>Night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td>Easy bruising</td>
<td></td>
<td></td>
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<tr>
<td>Unconscious spells</td>
<td></td>
<td></td>
<td>Heart palpitation</td>
<td></td>
<td></td>
<td>Sun sensitivity</td>
<td></td>
<td></td>
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<tr>
<td>Blurred/Double vision</td>
<td></td>
<td></td>
<td>Belching/Heartburn</td>
<td></td>
<td></td>
<td>Heat sensitivity</td>
<td></td>
<td></td>
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<tr>
<td>Eyes red/gritty/pain/dry</td>
<td></td>
<td></td>
<td>Stomach ulcer</td>
<td></td>
<td></td>
<td>Cold sensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
<td></td>
<td>Nausea/Vomiting</td>
<td></td>
<td></td>
<td>Hair loss</td>
<td></td>
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<tr>
<td>Ringing in ears</td>
<td></td>
<td></td>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>Bleeding gums or gum disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose bleeds</td>
<td></td>
<td></td>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus problems</td>
<td></td>
<td></td>
<td>Blood in stool</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Last dental examination ______________
Have you ever been vaccinated against:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (German measles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyme Disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you been diagnosed and/or treated for cancer?

What kind __________________________________________ When:________________

What type of treatment & dates: __________________________________________

Have you been diagnosed and/or treated for a psychiatric disorder or sought counseling?

What type:____________________________________________

Describe treatment & dates:__________________________________________

Have you been hospitalized for any illness? Please describe:

________________________________________________________________________

________________________________________________________________________

Have you ever had injuries (broken bones, concussion, etc.) or accidents? Please describe & date

________________________________________________________________________

________________________________________________________________________

Have you had any surgery? Please describe & date

________________________________________________________________________

________________________________________________________________________

Have you had a blood or plasma transfusion?______________

Allergies (drugs, food, etc.)

________________________________________________________________________
FAMILY & GENETIC HISTORY

MEDICAL

Any of your blood relatives have:

- Stroke ___ who _______
- Heart Disease ___ who _______
- High Blood Pressure ___ who _______
- Diabetes___ who ________
- Blood Clots/Phlebitis ___ who _______
- Arthritis ___ who ________
- Tuberculosis ___ who ________
- Alcoholism ___ who ________
- Cancer ___ Type ____________________________ who __________________________
- Psychiatric Disorder ___ Type ___________________ who __________________________
- Other medical problems __________________________________________________________

GENETIC

Do you have any children with birth defects, handicaps, or a genetic disease? ___

Explain _______________________________________________________________________

Are you and your partner blood relatives? _____ Explain ________________________________

Any of your blood relatives have the following: (check)

<table>
<thead>
<tr>
<th>Anencephaly (open skull)</th>
<th>Hemophilia (bleeding disorder)</th>
<th>Neurofibromatosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness or Eye problem</td>
<td>Huntington’s disease</td>
<td>Neuologic disorders</td>
</tr>
<tr>
<td>Bone disorder</td>
<td>Infertility – Miscarriages</td>
<td>Phenylketonuria</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>Kidney disease</td>
<td>Short stature (under 5 ft.)</td>
</tr>
<tr>
<td>Chromosomal abnormality</td>
<td>Limb defects</td>
<td>Sickle cell anemia</td>
</tr>
<tr>
<td>Clef lip/palate</td>
<td>Malformation at birth</td>
<td>Skin condition</td>
</tr>
<tr>
<td>Deafness</td>
<td>Mental illness</td>
<td>Slow growth in child</td>
</tr>
<tr>
<td>Down Syndrome (Mongolism)</td>
<td>Mental retardation</td>
<td>Spina Bifida (open spine)</td>
</tr>
<tr>
<td>Epilepsy or Seizures</td>
<td>Muscular Dystrophy</td>
<td>Tay Sachs disease</td>
</tr>
<tr>
<td>Heart defects</td>
<td>Myotonic Dystrophy</td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity:

What is your ethnic background?

What countries or parts of the world are your ancestors from?

Do you have any of the following in your ancestry:

<table>
<thead>
<tr>
<th>African American</th>
<th>Celtic – English Isle</th>
<th>French Canadian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cajun</td>
<td>Hispanic</td>
<td>Mid-Eastern</td>
</tr>
<tr>
<td>Carribean</td>
<td>Indian</td>
<td>Greek</td>
</tr>
<tr>
<td>Caucasian</td>
<td>Italian</td>
<td>Others specify</td>
</tr>
<tr>
<td>Eastern European</td>
<td>Oriental</td>
<td></td>
</tr>
</tbody>
</table>

Have you been tested for any of the following? If so, indicate carrier (c) or non-carrier (n)

<table>
<thead>
<tr>
<th>Sickle cell trait</th>
<th>Tay Sachs disease</th>
<th>Cystic fibrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha or Beta thalassemia</td>
<td>Canavan’s disease</td>
<td>Gaucher’s disease</td>
</tr>
</tbody>
</table>
Social & Environmental History

Residence & Travel
Country of birth _______________ Have you lived outside the US ___________
Where & When ________________________________________________________________
Do you or your partner regularly travel outside US ______
Where & How Often ____________________________________________________________

Domestic
Who lives in your household:__________________________________________________
Are you a caretaker outside your home? Who _________________________________
Do you have smoke detectors ____  Do you have cats in your household _____

Occupation
What is it? _____________________________
Describe your typical work day:_______________________________________________
Do you commute: _______ How long: ________ Use seat belt? ______

Toxic Exposures – Are you regularly exposed to, in contact with or consume:

<table>
<thead>
<tr>
<th>Aluminum utensils</th>
<th>Herbicides</th>
<th>Plastic wrap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetic gasses</td>
<td>Lead (old paint/pipes)</td>
<td>Radiation</td>
</tr>
<tr>
<td>Anti acids</td>
<td>Microwave</td>
<td>Video monitor</td>
</tr>
<tr>
<td>Copper/brass jewelry</td>
<td>Mothballs</td>
<td>Blood borne diseases</td>
</tr>
<tr>
<td>Electric blanket</td>
<td>Organic chemicals</td>
<td>Viral diseases</td>
</tr>
<tr>
<td>Foil wrap</td>
<td>Paint stripper</td>
<td>Cats</td>
</tr>
<tr>
<td>Food additives</td>
<td>Pesticides</td>
<td>Rare/Raw meat</td>
</tr>
</tbody>
</table>

Domestic Violence
*You may choose to answer the following questions personally if you prefer
In the past 12 months:
Has anyone threatened you with or actually used a knife or gun to scare or hurt you? ___
Has anyone choked, kicked, bit or punched you? ___
Has anyone slapped, pushed, grabbed or shoved you? ___
Has anyone forced or coerced you to have sex? ___
Have you been afraid that a current or former intimate partner would hurt you physically?
If any of the above answer is yes:
What is the relationship with the person who hurt you? _________________________
Have the police been notified? ______ When: ________________________________
NUTRITION, WELLNESS & LIFESTYLE

Height _____ Weight: Now _____ One year ago _____ Maximum _____ When? __________________

Describe weight fluctuation _________________________________________________

I consider my weight to be: (Please check which statement applies to you)

____ not a factor in my present health issues
____ somewhat a factor
____ a significant factor

Do you smoke? _____ If so, how many packs per day? ____

Are you exposed to second hand smoke? __________

Do you drink alcohol? _____ How many drinks per week? ____

Do you drink caffeinated coffee? _____ How much? ____

Have you ever used intravenous drugs? _____

Please describe your present eating style (Please check any that apply)

Omnivore (Include meat/poultry/fish/eggs/dairy) _____

Semi-vegetarian _____ (I exclude some animal products, specifically ________________________________).  

Ovo-lactovegetarian (I exclude all animal flesh but include dairy and eggs) _____

Vegan (I do not include any animal products) _____

Macrobiotic _____

Other (Please describe) ___________________________________________________________________

How many times per week do you eat red meat? _____

How many times per week do you eat chicken or fish? _____

How many times per week do you eat desserts? _____

Indicate how many servings of fruits and vegetables you eat per day____

How many whole eggs do you eat a week? _____

How often do you eat out? _____

Do you eat unpasteurized cheese or unpackaged deli meat or cheeses _____

Do you regularly add salt at the table? _____

I have food allergies and/or intolerances (please describe) ___________________________

I tend to eat pretty much the same things on a regular basis, i.e., not a lot of variety____

I tend to skip meals, specifically _______________________________________________

I tend to snack a lot, specifically throughout the day____; mainly at night____

I tend to overeat if I am not careful ______

I often succumb to food cravings, specifically_______________________________

I am concerned about getting optimum nutrition because of __________________________

Briefly, how would you describe your diet (what ever you want to say)____________________________

______________________________________________________________________________________

______________________________________________________________________________________

Recent improvements that I have made in my diet include______________________________

______________________________________________________________________________________

The factors in my life that interfere with eating better are______________________________

______________________________________________________________________________________

My interest and motivation to make and sustain improvements in my diet at this time are:

_____ none _____ slight _____ moderate _____ strong _____ very strong
Do you participate in aerobic exercise? _____ How often? _____
How many minutes do you exercise at one time? _____
Do you perform strength training or floor exercises, resistance training or lift weights? _____
Do you stretch regularly? _____
Describe any physical problems that prevent you from exercising ______________________________
Have you felt tired, worn out, or exhausted during the past month? _____
How often do you get at least 7 to 8 hours of sleep each day? _____
Do you often have insomnia? _____
Do you consider yourself generally happy these days? _____
Do you feel as though you have a strong social support system/people to talk to, share things with (family, friends)? _____
How many sick days have you taken in the past 12 months due to sickness or injury? _____
Do you feel as though you are often under stress or pressure? _____
On a scale from 0 to 10, where 0 is a thoroughly easy-going person and 10 is a very high-strung person, please rate how you generally consider yourself. _____ How do you think others would rate you? _____

Please identify the three biggest stresses in your life right now
1. _____
2. _____
3. _____

If there were three things you could change about yourself right now, what would they be?
1. _____
2. _____
3. _____

Please describe two or three of your greatest strengths and/or achievements
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Are you generally satisfied with your job? _____

Please describe any physical factors or environmental problems at work that impact your health, safety or job satisfaction (for example: temperature, workspace, relations with coworkers, etc.)
________________________________________________________________________
________________________________________________________________________

How important is spirituality in your daily life? (Not important) 1 2 3 4 5 (Very Important)
Do you participate in a faith community? _____
What is your religious affiliation? ________________________
How important is your religious affiliation in your daily life? (Not important) 1 2 3 4 5 (Very important)
MALE FERTILITY HISTORY

Have you ever fathered a pregnancy before?_______
  If so, was the pregnancy miscarried or aborted?_____
  Do you have any children?________
    What is the health of the child or children?__________________________

Have you ever had sores or rashes of the penis?

Have you previously been treated for a sexually transmitted disease?________

Have you ever had any genital injuries or surgeries?_____________________

Have you ever sought evaluation or treatment for difficulty conceiving?_______
  If so, what tests or treatments have you had, and what were the result?________
    _____________________________________________________________________
    _____________________________________________________________________
OBSTETRIC, GYNECOLOGIC & FERTILITY HISTORY

Date of last gynecologic exam ___________ Pap smear result ______ Previous abnormal____
Date of last mammogram______________

Current method of birth control: Pills ___ Injections ___ Condom/Diaph ___ IUD ___ Rhythm ___ None ___
Past method of birth control: Pills ___ Injections ___ Condom/Diaph ___ IUD ___ Rhythm ___ None ___

Previous Gynecologic Surgery (list date, type, indication):

Do you have history of:
Painful intercourse ____ Sexual dysfunction ________________________________________________
Genital Herpes ____ Genital Warts ____ STD ____ Recurrent vaginal infections ____
Partner with penile discharge or sores ______
Uterine Fibroids______ Endometriosis ______ Infertility_______
Ovarian cysts______ Fibrocystic Breasts_______
Have you ever been tested for chlamydia or gonorrhea__________
Have you been tested for chlamydia or gonorrhea during this relationship_________

Menstrual History
Date of last menstrual period: _____________ Age of onset: ______
Length of menstruation _______days Frequency, every ________days
Amount: ___ Heavy ___ Medium ___ Light
Cramps: ___ Severe ___ Moderate ___ Mild
Abnormal Period _____ Describe:
Medications (including herbs):

Pregnancy History

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of Delivery</th>
<th>Miscarriage/Termination</th>
<th>Length of Pregnancy</th>
<th>Complication</th>
<th>Health of Child</th>
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Infertility History
Primary infertility ____ How long ____ Secondary infertility ____ How long ____
Male factor ____ What kind _______________________________________________
Work-up: ______ Hormonal/BBT ___ HSG ___ Laparoscopy ___
Result: _________________________________________________________________
Treatment: Ovulation induction ____ Corrective surgery ____ IVF ___
Describe: __________________________________________________________________
Medications (including herbs): _____________________________________________
**COMPLEMENTARY ALTERNATIVE MEDICAL CARE HISTORY**

Please check each type of complementary care that you have tried or that interests you:

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<th>TRIED</th>
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<tr>
<td>Acupuncture</td>
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<td>Massage Therapy</td>
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<td>Alexander Technique</td>
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<td>Meditation</td>
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<td>Chinese Herbs</td>
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<td>Mind-Body Medicine</td>
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<td>Western Herbs</td>
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<td>Nutrition Counseling</td>
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<td>Chiropractic</td>
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<td>Reiki</td>
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<td>Guided Imagery</td>
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<td>Spiritual Direction</td>
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<td>Homeopathy</td>
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<td>Yoga</td>
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Others: __________________________________________________________________________

If you have already tried a complementary therapy, please explain the reason you selected the therapy and your goals. How effective has the therapy been? __________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Please list the practitioners: __________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

____________________________________________________________

Do you use herbs or vitamin supplements? What are you using? For what purpose?_______________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
MEDICATION HISTORY

What prescription medications are you now taking or have you taken in the past?

<table>
<thead>
<tr>
<th>Medication and Dose</th>
<th>Indication</th>
<th>Start Date</th>
<th>Stop Date</th>
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What nonprescription (over-the-counter) medications are you now taking or have you taken in the past?

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<th>Stop Date</th>
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October 2002