Fertility Specialist Intake Questionnaire

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Partner's Name (if applicable)

Reproductive History

Years attempting to conceive

Number of pregnancies

Number of live births

Previous fertility treatments

Medical History

Current medications

Medical conditions

Allergies

Family history of infertility

Menstrual History

Age at first period

Cycle length (days)

Regularity of cycles

Painful periods

Lifestyle

Smoking

Alcohol use

Exercise frequency

Dietary habits

Concerns/Goals

Please share your main concerns or goals for this visit