Name:_____ Date_____

Fertility - Part 1a

Instructions: There are eleven (11) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your fu-ture should this condition continue.

Name your Primary Complaint: ☐ Inability to conceive ☐ Miscarriage ☐ Repeat miscarriage(s)
☐ Painful Intercourse ☐ Low libido/arousal ☐ Poly-pregnancy ☐ Other_____

Indicate all abnormalities or exacerbated conditions that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought _____ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?

_____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

_____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

_____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____

_____

What provides relief to the primary complaint? _____

_____

_____

_____

Please answer the following:

Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Does excess weight caused pain?	☐ No	☐ Yes	☐ Unknown
Has excess weight damaged joints?	☐ No	☐ Yes	☐ Unknown
Does a sibling have this weight issue?	☐ No	☐ Yes	☐ Unknown
Does a parent have this weight issue?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Do you have a food allergy?	☐ No	☐ Yes	☐ Unknown
Are you on prescription medication?	☐ No	☐ Yes	
Are you taking OTC medicines?	☐ No	☐ Yes	
Are you taking illicit drugs?	☐ No	☐ Yes	
Are you taking herbs?	☐ No	☐ Yes	
Do you smoke tobacco?	☐ No	☐ Yse	

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Fertility Part 1a

Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 Tel/Fax 310-310-8096 info@vanharding.com

Name:_____ Date:_____

FERTILITY - Part 1b

1. RACE (You)

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

Significant Other

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

2. ETHNICITY

❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

3. PREGNANCY HISTORY

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____ Elective abortion _____ Adopted children ____

Date	Miscarriage	Elective Abortion	Ectopic	Months to conceive?	Infertility Treatment	Weight and Sex?	C-section?	Complications?	Is current Partner the father?
1.									
2.									
3.									
4.									

4. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1.		
2.		
3.		

5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1.				
2.				
3.				

6. **MEDICATIONS** *List all prescriptions and over-the-counter drugs used during the past year*

Date	Dose and Frequency	From when to when	Reason
1.			
2.			
3.			

7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Fertility Part 1a

8. MENSTRUAL/HORMONAL

Height _____ Weight _____ Blood Type (if known) _____

Age at first period ..... Date of last two menstrual periods _____/_____/_____ and _____/_____/_____

Are your periods regular? ❑ yes ❑ no Do you bleed between periods? ❑ yes ❑ no

How many days from onset to onset? ..... What is the usual duration of your periods? .....days

Premenstrual symptoms occur: ❑ almost always ❑ rarely ❑ never

Vigorous exercise: type ..... hrs/week ..... type ..... hrs/week.....

If you have a hormonal disorder, please specify type and treatment: .....

Last pap smear _____/_____/_____ Last mammogram _____/_____/_____

Pelvic pain/cramps: ❑ none ❑ during menses ❑ before menses ❑ after menses ❑ at midcycle

❑ during intercourse ❑ with bowel movements ❑ with urination ❑ cause you to miss work ❑ cause you to miss usual activities

Pelvic pain/cramps are: ❑ mild ❑ moderate ❑ severe

❑ worsening ❑ improving ❑ no change ❑ in midline ❑ on right side ❑ on left side

Frequency of intercourse _____

Do you have or have you had? (Check all that apply).

❑ Hot flushes	❑ Increased facial or body hair	❑ Seizures
❑ Breast discharge	❑ Increased acne	❑ Diabetes
❑ Visual disturbance	❑ Weight increase > 10 pounds	❑ Thyroid disorder
❑ Poor sense of smell	❑ Weight loss > 10 pounds	❑ Autoimmune disease
❑ Chronic headache	❑ Special dietary habits	❑ Extraordinary stress
❑ Head trauma	❑ Vomiting	❑ Psychiatric treatment

Please explain a "Yes" answer: _____

_____

_____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

❑ Pelvic infection	❑ Appendicitis	❑ Gonorrhea	❑ Ovarian cysts
❑ Chlamydia	❑ Colitis or enteritis	❑ Syphilis	❑ Toxoplasmosis
❑ Endometriosis	❑ Uterine fibroids or myomas	❑ Mycoplasma	❑ Cytomegalovirus (CMV)
❑ Pelvic adhesions	❑ Abnormal uterus shape	❑ Ureaplasma	❑ Tuberculosis
❑ Cervicitis	❑ Recurrent vaginitis	❑ Genital warts / condyloma	❑ Trichomonas
❑ Genital herpes	❑ Abnormal Pap smears	❑ Cryo (freezing) or surgery of the cervix	

10. OTHER HISTORY

Your occupation: ..... Spouse's occupation: ……

Cigarettes - packs smoked per day:.....

Alcohol - type and number per week:…….....

Marijuana - amount: .....…

Other drugs - type and amount: .....…

Caffeine drinks per day: .....…

Video display terminal hours / day:.....

Electric blanket use:	❑ yes ❑ no	Toxic exposure:	❑ yes ❑ no
Ever used intravenous drugs?	❑ yes ❑ no	Hot tub or sauna use:	❑ yes ❑ no
Radiation exposure:	❑ yes ❑ no		

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Fertility Part 1a

11. MEDICAL ILLNESSES

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Please explain a "Yes" answer to any of the above:……

……

……

12. FAMILY HISTORY

	Living?	Age or age at death	Health Problems
Mother	:	:	:
Father	:	:	:
Sister(s)	:	:	:
	:	:	:
	:	:	:
Brother(s):	:	:	:
	:	:	:
	:	:	:
Daughter(s)	:	:	:
	:	:	:
Son(s)	:	:	:
	:	:	:

Which of your blood relatives have?

Cancer .....

Venous Thrombosis (blood clotting)……

Diabetes .....

Hypertension .....

High Cholesterol .....

Heart disease .....

Stroke .....

Premature menopause .....

Endometriosis .....

Uterine fibroids (myomas) .....

13. GENETIC HISTORY

Do you, your partner, or anyone in either family have? ❑ Any inherited disorders?

- ❑ Neural tube defects/spina bifida/anencephaly
- ❑ Thalassemia
- ❑ Down syndrome
- ❑ Cystic fibrosis
- ❑ Muscular dystrophy
- ❑ Huntington chorea
- ❑ Mental retardation / fragileX
- ❑ Tay-Sachs disease
- ❑ Sickle cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal disorder
- ❑ Chromosomal disorder
- ❑ Genetic / inherited disorder
- ❑ Baby with birth defects
- ❑ Infertility

Please explain a "Yes" answer to any of the above:……

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Fertility Part 1a

14. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____

- ❑ mild
- ❑ moderate
- ❑ severe
- ❑ improving
- ❑ worsening
- ❑ no change
- ❑ with visual symptoms
- ❑ with vomiting
- ❑ stress related
- ❑ migraines

- ❑ Wear glasses
- ❑ Wear contact lenses
- ❑ Sinus problems
- ❑ Hayfever
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Denture / bridges

- ❑ Anemia
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting spells
- ❑ Leg swelling
- ❑ Calf pain
- ❑ Blood clots (venous thromboembolism)
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough up blood
- ❑ Chest x-ray
- ❑ TB skin test

- ❑ Bladder/kidney infections
- ❑ Urgent / frequent / painful urination
- ❑ Blood / abnormal color of urine
- ❑ Unable to control urination
- ❑ Abnormal urinary tract
- ❑ Kidney x-ray
- ❑ Bladder cystoscopy

- ❑ Varicose veins
- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ Bleeding from gums
- ❑ Nosebleeds
- ❑ Take aspirin/ibuprofen frequently

- ❑ Breast mass
- ❑ Fibrocystic changes
- ❑ Breast implants
- ❑ Mammogram
- ❑ Do monthly breast self-exam

- ❑ Abdominal pain
- ❑ Nausea and vomiting
- ❑ Vomiting blood
- ❑ Ulcer
- ❑ Food intolerance
- ❑ Gallstones
- ❑ Jaundice / hepatitis
- ❑ Chronic constipation
- ❑ Diarrhea
- ❑ Blood in bowel movement
- ❑ Irritable bowel
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Abnormal liver test
- ❑ Arthritis
- ❑ Back pain

- ❑ Acne
- ❑ Skin disorder
- ❑ Rash
- ❑ Hives
- ❑ Skin cancer

- ❑ Counseling
- ❑ Recent stress increase
- ❑ Recent anxiety increase

- ❑ Sensation loss / numbness
- ❑ Muscle control / weakness
- ❑ Heat or cold intolerance
- ❑ Damp skin
- ❑ Unusual hair loss
- ❑ Extraordinary fatigue

OTHER: _____

_____

_____

15. MALE HISTORY:

- ❑ Medications:
- ❑ Illnesses:
- ❑ Mumps:
- ❑ Smoker:
- ❑ Alcohol:
- ❑ Ejaculatory Disorder:
- ❑ Reproductive surgery:
- ❑ STDs:
- ❑ Testicular trauma:
- ❑ Impotence:
- ❑ Allergies: _____

Have you seen a urologist for infertility? ❑ Yes ❑ No
If yes: Physician name and location ……..

Have you ever fathered a child/pregnancy with another woman? ❑ Yes ❑ No
If yes, when? …….. years ago

Have you ever been diagnosed with an infertility diagnosis except for currently? ❑ Yes ❑ No
If yes, when? …….. years ago

Comments:_____

_____

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Fertility Part 1a

16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? ❑ yes ❑ no
If yes, who was your physician? ……..

What cause of infertility was diagnosed? ……

What drugs have you taken for infertility? Please check all that apply:

❑ Clomid (Serophene)	❑ hCG Profasi	❑ Antibiotics
❑ Gonal F	❑ Progesterone	❑ Baby aspirin
❑ Follistim	❑ Lupron	❑ Heparin
❑ Repronex	❑ Microdose Lupron	❑ Steroids
❑ Pergonal	❑ Antagon	❑ Oral Contraceptives
❑ Fertinex	❑ Parlodel	❑ Other ……..……

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ BBT	When _____/_____/_____	Results ……..
❑ Postcoital Test	When _____/_____/_____	Results ……..
❑ Hormonal Assays (FSH, LH, Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone)	When _____/_____/_____	Results ……..
❑ Endometrial biopsy	When _____/_____/_____	Results ……..
❑ Hysterosalpingogram	When _____/_____/_____	Results ……..
❑ Sonohystogram	When _____/_____/_____	Results ……..
❑ Ultrasound	When _____/_____/_____	Results ……..
❑ Laparoscopy, Hysteroscopy	When _____/_____/_____	Results ……..
❑ Mycoplasma culture	When _____/_____/_____	Results ……..
❑ Chlamydia culture	When _____/_____/_____	Results ……..
❑ GC Culture	When _____/_____/_____	Results ……..
❑ Thyroid tests	When _____/_____/_____	Results ……..
❑ Rubella (German measles)	When _____/_____/_____	Results ……..
❑ Varicella (Chicken pox)	When _____/_____/_____	Results ……..
❑ Cytomegalovirus (CMV)	When _____/_____/_____	Results ……..
❑ Antibody screen	When _____/_____/_____	Results ……..
❑ Blood type	When _____/_____/_____	Results ……..
❑ Chromosomes	When _____/_____/_____	Results ……..
❑ Genetic screening	When _____/_____/_____	Results ……..
❑ Hepatitis B	When _____/_____/_____	Results ……..
❑ Hepatitis C	When _____/_____/_____	Results ……..
❑ HIV	When _____/_____/_____	Results ……..
❑ HTLV	When _____/_____/_____	Results ……..
❑ RPR (Serology)	When _____/_____/_____	Results ……..
❑ Semen analysis	When _____/_____/_____	Results ……..
❑ Antisperm antibodies	When _____/_____/_____	Results ……..
❑ Varicocele repair	When _____/_____/_____	Results ……..
❑ Testicular biopsy	When _____/_____/_____	Results ……..

❑ OTHER: ……

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ❑ yes ❑ no
If yes, ❑ partner ❑ donor sperm

Clomid ❑ yes ❑ no Fertility Shots ❑ yes ❑ no name of medications_____

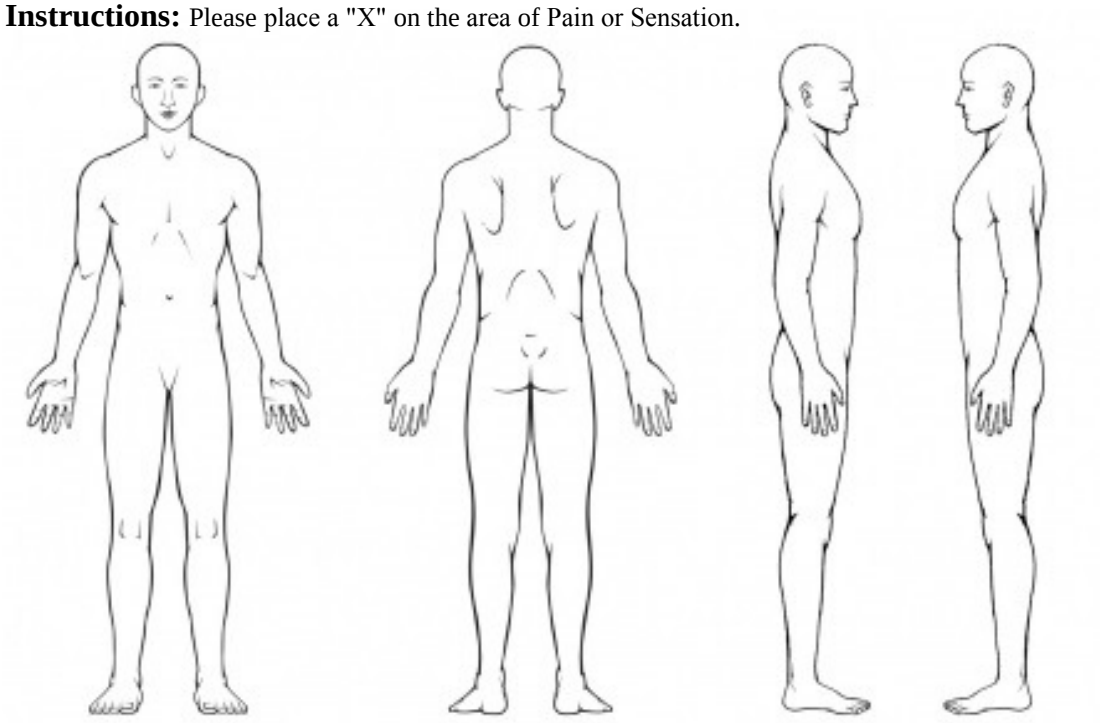
#IUI's _____ Dates_____

#IVF cycles _____ Dates_____

Name:_____ Date_____

Fertility - Part 1c

Instructions: Please place a "X" on the area of Pain or Sensation.



Front Rear Right Left

Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant ☐ Fixed
- ☐ Intermittent ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

Are you hands or feet too sensitive to touch? ☐ Yes ☐ No
Does it hurt at night when bed covers touch? ☐ Yes ☐ No
Do your symptoms worsen at night? ☐ Yes ☐ No
Do your legs feel weak when you walk? ☐ Yes ☐ No
Do your legs/feet hurt when you walk? ☐ Yes ☐ No
Are your feet skin dry and crack open? ☐ Yes ☐ No
Can your feet discern hot/cold water in tub/shower? ☐ Yes ☐ No
Do your legs/feet experience 'asleep feeling' or loss of sensation? ☐ Yes ☐ No
Are you unable to sense you feet when you walk? ☐ Yes ☐ No
Do you have sharp, stabbing or shooting pain in our feet? ☐ Yes ☐ No

What provides relief of Pain or sensation?_____

_____
_____
_____
_____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Fertility Part 1c

Name:_____ Date_____

Use the next four (4) pages to embellish upon the details of your PAIN and Life Experiences.

Fertility - Part 2

Instructions: The Day your Fertility Issue became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the Fertility Issue (or a medical diagnosis that was given),
- how you felt and any emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the Physical Sensation(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Fertility Issue or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Fertility Part 2

Name:_____ Date_____

Fertility- Part 3

Instructions: Your Life Prior to the Day the Fertility Issue became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Fertility Issue and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Fertility Issue became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarceration institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Fertility Issue or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Fertility Part 3

Name:_____ Date_____

Fertility - Part 4

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the Fertility Issue or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Fertility Issue and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your PAIN became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Fertility Issue or associated symptoms:

Name:_____ Date_____

Fertility - Part 5

Instructions: Your Symptoms and Actions since the day your Fertility Issue or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Fertility Issue or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Fertility Issue or associated symptoms became disruptive to ADL or causative to significant impairment.

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Fertility Part 5