Women's Fertility History

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Name: _____ **Date: _____**

Age at which menses began _____

Are your periods painful? □yes □no

How many days does the pain last? _____

How many days do you normally bleed?_____

How heavy is the bleeding? □light □normal □heavy

What color is the blood □light red □normal
□dark red □purple □brown □black

Is there clotting? □yes □no
□small □medium □large

Do you have premenstrual tension? □yes □no

Does your face break out before or during your period? □yes □no

Do your breasts become tender premenstrually?
□yes □no

Do you bleed or spot between periods? □yes □no

Are your menstrual cycles spaced irregularly?
□yes □no

How many days are there from one period to the next?
_____

Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear?
□yes □no

Have you ever had a cervical biopsy, operation, cauterization or conization? □yes □no

Have you ever had a venereal disease? □yes □no

Do you get yeast infections regularly? □yes □no

Have you ever been diagnosed with chlamydial infection? □yes □no

Do you have chronic vaginal discharge? □yes □no

Do you have any sores on your genitalia □yes □no

Have you ever had pelvic inflammatory disease?
□yes □no Where you treated for it? □yes □no
How _____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? □yes □no

Have you ever been diagnosed with endometriosis?
□yes □no

Have you been diagnosed with any pelvic abnormalities? □yes □no

Have you taken any medications for gynecological conditions other than contraceptive?

Medication	**Reason**	**How long?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began?
□yes □no How? _____

Do you ovulate on your own? □yes □no

On what day of your cycle? _____

Do your breast get tender at/during ovulation?
□yes □no

Do you get premenstrual low back pain? □yes □no

Do your bowel movements become loose at the beginning of your periods? □yes □no

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Have you had diagnosis relating infertility? □yes □no

What was it? _____

Have you had fertility treatments? □yes □no

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate?
□yes □no When _____ How long? _____

Have your fallopian tubes been evaluated medically?
□yes □no What where the results? _____

Have you had any tubal operations? □yes □no

Have you had any hormone laboratory test performed?
□yes □no What were the results? _____
_____

Do you have a single partner with whom you have been trying to conceived? □yes □no

How long have you been married or living together?
_____

Has he had a fertility workup? □yes □no

What were the results? _____

Is your partner supportive of your wish to conceive?
□yes □no Of using acupuncture? □yes □no

Have you taken oral contraceptive? □yes □no

When _____ How long? _____

Have you ever had and IUD? □yes □no

When _____ How long? _____

Have you ever taken DepoProvera? □yes □no

When _____ How long? _____

How long have you been trying to conceive? _____

How is your sexual energy? □low □normal □high

Do you douche regularly? □yes □no

With what? _____

Do you use vaginal lubricants? □yes □no

Are you more than 20% over your ideal body weight?
□yes □no

Are you more than 20% below your ideal body weight? □yes □no

Do you have a stressful occupation? □yes □no

Do you exercise regularly? □yes □no

Do you have excessive facial hair? □yes □no

Do you have excessive oily skin? □yes □no

Have you experience excessive loss of head hair?
□yes □no

Have you noticed discharge from your nipples?
□yes □no

Have you been exposed to any known enviormental toxins or hormones? □yes □no

Are you presently taking steroids? □yes □no

ADDITIONAL COMMENTS:

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_____

_____

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