

## Women's Fertility History

Name: \_\_\_\_\_

**Menstruation**

Age at which menses began: \_\_\_\_\_ Duration of menstrual cycle: \_\_\_\_\_

Color of blood on day one: \_\_\_\_\_ Color of blood on subsequent days: \_\_\_\_\_

- Pale red
- Red
- Deep Red
- Brown

Clotting:

- Yes
- No

Blood Constitution:

- Watery
- Thick
- Thin

Bleeding:

- Light
- Normal
- Heavy

**Before or during the menstrual cycle, how often do you experience any of the following?**

	Often	Seldom	Severe	Mild	None		Often	Seldom	Severe	Mild	None
Breast tenderness						Cramping better with heat?					
Breast distention						Bearing down sensation					
Better with exercise						Breast Lumps					
Loose stools						Food Cravings					
Acne before or during period						Bleeding or spotting between periods					
Mood changes						Low back pain					

Are your menstrual cycles spaced irregularly?  Yes  No

Days from one period to the next: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

	<u>Number</u>	<u>Year</u>
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 chlamydial infection?  Yes  No
- Have you ever had a venereal disease?  Yes  No
- Do you have chronic vaginal discharge?  Yes  No
- Do you have any sores on your genitalia?  Yes  No
- Do you get yeast infections regularly?  Yes  No
- Have you ever had pelvic inflammatory disease?  Yes  No  
 Were you treated for it?  Yes  No How? \_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_

Have you ever been diagnosed with any of the following?

- |                  |  |                    |  |
|------------------|--|--------------------|--|
| Uterine fibroids | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pelvic adhesions   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Polyps           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pelvic abnormality | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Endometriosis    | <input type="checkbox"/> Yes <input type="checkbox"/> No | PCOS               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you taken any medications for gynecological conditions other than contraceptives?  Yes  No

<u>Medication</u>	<u>Reason</u>	<u>How long</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began?  Yes  No  
How? \_\_\_\_\_

Do you ovulate on your own?  Yes  No What date? \_\_\_\_\_

Do your breasts get tender at/during ovulation?  Yes  No

Have you had fertility treatments?  Yes  No

If yes, where and when \_\_\_\_\_

By whom? \_\_\_\_\_ What types? \_\_\_\_\_

Have you taken medication to help you ovulate?  Yes  No

What? \_\_\_\_\_ When? \_\_\_\_\_ How long \_\_\_\_\_

Have your fallopian tubes been evaluated medically?  Yes  No

What were the results? \_\_\_\_\_

Have you had any tubal operations?  Yes  No

Have you had any hormone laboratory tests performed?  Yes  No

What were the results? \_\_\_\_\_

Have you taken oral contraceptives?  Yes  No When?\_\_\_\_\_ How long?\_\_\_\_\_

Have you ever had and IUD?  Yes  No When?\_\_\_\_\_ How long?\_\_\_\_\_

Have you ever taken Depo-Provera?  Yes  No When?\_\_\_\_\_ How long?\_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

Have you had a diagnosis related to infertility?  Yes  No

What was it?\_\_\_\_\_

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  Yes  No  
If yes, with what?\_\_\_\_\_

Do you use vaginal lubricants?  Yes  No

Are you more than 20% over your ideal bodyweight?  Yes  No

Are you more than 20% under your ideal bodyweight?  Yes  No

Do you have a stressful occupation?  Yes  No  
On a scale of 1-10 what is your stress level?\_\_\_\_\_

Do you exercise regularly?  Yes  No  
How often? ?\_\_\_\_\_

Do you have excessive facial hair?  Yes  No

Do you have excessively oily skin?  Yes  No

Have you experienced excessive loss of hair?  Yes  No

Have you had discharge from your nipples?  Yes  No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?  Yes  No

Have you been exposed to any known environmental toxins or hormones?  Yes  No

Are you presently taking steroids?  Yes  No

Are you presently taking anticoagulants?  Yes  No

Has your partner been medically evaluated?  Yes  No

What were the results?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_