Women's Fertility History

Name: _____

Menstruation

Age at which menses began: _____ Duration of menstrual cycle: _____

Color of blood on day one:
- ☐ Pale red
- ☐ Red
- ☐ Deep Red
- ☐ Brown

Color of blood on subsequent days:_____

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: _____

	Number	Year
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	☐ Yes ☐ No	Pelvic adhesions	☐ Yes ☐ No
Polyps	☐ Yes ☐ No	Pelvic abnormality	☐ Yes ☐ No
Endometriosis	☐ Yes ☐ No	PCOS	☐ Yes ☐ No

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

Medication	Reason	How long

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?_____

_____

_____