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

Polyps ☐ Yes ☐ No

Endometriosis ☐ Yes ☐ No

Pelvic adhesions ☐ Yes ☐ No

Pelvic abnormality ☐ Yes ☐ No

PCOS ☐ Yes ☐ 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?______________________________

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