

### Woman's Fertility History

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

Age when menstruation began: \_\_\_\_\_ Duration of menstrual cycle: \_\_\_\_\_

Are your menstrual cycles regular?  No  Yes

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

Are you pregnant now:  No  Yes  Don't know (maybe)

Color of blood on day one:	Color on subsequent days:	Pain with cycle:
<input type="checkbox"/> Pale red	<input type="checkbox"/> Pale red	<input type="checkbox"/> Mild
<input type="checkbox"/> Red	<input type="checkbox"/> Red	<input type="checkbox"/> Medium
<input type="checkbox"/> Deep red	<input type="checkbox"/> Deep red	<input type="checkbox"/> Severe
<input type="checkbox"/> Brown	<input type="checkbox"/> Brown	

Clotting:	Blood constitution:	Bleeding:
<input type="checkbox"/> Yes	<input type="checkbox"/> Watery	<input type="checkbox"/> Light
<input type="checkbox"/> No	<input type="checkbox"/> Thin	<input type="checkbox"/> Normal
	<input type="checkbox"/> Thick	<input type="checkbox"/> Heavy

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

	None	Seldom	Mild	Often	Severe
Breast distention					
Breast tenderness					
Breast lumps					
Better with exercise					
Loose stool					
Acne before or during period					
Mood changes					
Cramping better with heat					
"Bearing-down" sensation					
Food cravings					
Bleeding/spotting between periods					
Low-back pain					

### Obstetrical History

How long have you been trying to have a baby: \_\_\_\_\_

Have you ever been pregnant?  No  Yes

Date	Current/ prior partner	Live Birth (Y/N)	Miscarry/ Abortion/ Ectopic	Wks.	Fetal heart (Y/N)	D&C (Y/N)	Mode of delivery	Sex	Wt.	Complications/ Comments

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

**Confidential**

- Have you ever had an abnormal Pap smear?  No  Yes
- Have you ever had a cervical biopsy, operation, cauterization, or conization?  No  Yes
- Have you ever had a chlamydial infection?  No  Yes
- Have you ever had a venereal disease?  No  Yes
- Do you have chronic vaginal discharge?  No  Yes
- Do you have any sores on your genitalia?  No  Yes
- Do you get yeast infections regularly?  No  Yes
- Have you ever had pelvic inflammatory disease?  No  Yes

Were you treated for it?  No  Yes How? \_\_\_\_\_

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

Have you ever been diagnosed with any of the following?

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

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

Medication	Reason	How long

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

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

Are your breasts tender at/during ovulation?  No  Yes

Have you had fertility treatments?  No  Yes

If yes, where & when? \_\_\_\_\_

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

Have you taken medication to aid ovulation?  No  Yes

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

Have your fallopian tubes been evaluated medically?  No  Yes

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

Have you had any tubal operations?  No  Yes

Have you had any hormone laboratory tests performed?  No  Yes

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

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

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

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

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

Have you had a diagnosis related to infertility?  No  Yes

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

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  No  Yes

If so, with what? \_\_\_\_\_

Do you use vaginal lubricants?  No  Yes

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

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

Is your occupation stressful?  No  Yes

On a scale of 1 to 10, what is your stress level? \_\_\_\_\_

Do you exercise regularly?  No  Yes

How often? \_\_\_\_\_

Do you have excessive facial hair?  No  Yes

Do you have excessively oily skin?  No  Yes

Have you experienced excessive loss of hair?  No  Yes

Have you had discharge from your nipples?  No  Yes

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

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

Are you presently taking steroids?  No  Yes

Are you presently taking anti-coagulants?  No  Yes

Has your partner been medically evaluated?  No  Yes

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

\_\_\_\_\_

\_\_\_\_\_