Women's Fertility History

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE) DATE

Age of first menses (period) _____

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 ☐ Red ☐ Dark red ☐ Purple ☐ Brown Black
Is there clotting? ☐ Yes ☐ No

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 your last menstrual period _____

	Number	Years
Number of pregnancies?	_____	_____
Number of children?	_____	_____
Number of abortions?	_____	_____
Number of miscarriages?	_____	_____
Number of D&C procedures?	_____	_____

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
Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No
Do you have chronic vaginal discharge? ☐ Yes ☐ No
Do you get yeast infections regularly? ☐ Yes ☐ No
Do you have any sores on your genitalia? ☐ 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 uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No
Have you ever had pelvic adhesions? ☐ Yes ☐ No
Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No
Have you taken any medications for gynecological conditions other than contraceptives? (Please list them below)

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? _____

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?
_____
_____

By whom?
_____

What types of fertility treatments?
_____
Have you taken medication to help you ovulate? ☐ Yes ☐ No
When? _____
How long? _____
Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results? _____

Do you have a single partner with whom you have been trying to conceive? ☐ 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

Have you taken oral contraceptives? ☐ Yes ☐ No
When _____
How long _____

Have you ever had an IUD? ☐ Yes ☐ No
Have you ever taken DepoProvera? ☐ Yes ☐ No
When _____
How long _____

Do your breasts 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 period? ☐ Yes ☐ No
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
What do you do? _____
How often? _____

Do you have excessive facial hair? ☐ Yes ☐ No
Do you have excessively oily skin? ☐ Yes ☐ No
Have you experienced excessive loss of head hair? ☐ Yes ☐ No
Have you notices discharge from your nipples? ☐ Yes ☐ No

Was you 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

Do you have any known food allergies? ☐ Yes ☐ No
If yes, what are they? _____
Do you refrain from eating these foods? ☐ Yes ☐ No
Have you or a family member been diagnosed with Celiac Disease? ☐ Yes ☐ No

How long have you been trying to conceive? _____
Have you had a diagnosis related to infertility? ☐ Yes ☐ No
If yes, what is it?
_____

From what country(ies) does your family originate?
_____