

FERTILITY HISTORY - WOMAN

CONFIDENTIAL

NAME LAST, FIRST, MIDDLE _____

DATE _____

Age at which menses began _____

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 last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____ age(s) _____

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 venereal disease? _____ Yes No

Do you get yeast infections regularly? _____ Yes No

Have you ever been diagnosed with a chlamydia infection? _____ Yes No

Do you have chronic vaginal discharge? _____ Yes No

Do you have any sores on your genitalia? _____

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 been diagnosed with 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? _____ Yes No

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? _____

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

Have you had fertility treatments? _____ Yes No
If yes, when and where? _____

By whom? _____

What types? _____

FERTILITY HISTORY - WOMAN

CONFIDENTIAL

NAME LAST, FIRST, MIDDLE _____

DATE _____

Have you taken medication to help you ovulate? _____ Yes No
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? _____

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
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
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 noticed 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
Have you taken oral contraceptives? _____ Yes No
When? _____
How long? _____
Have you ever had an IUD? _____ Yes No
When? _____
How long? _____
Have you ever taken DepoProvera? _____ Yes No
When? _____
How long? _____
How long have you been trying to conceive? _____
Have you had a diagnosis relating to infertility? _____ Yes No
What was it? _____

COMMENTS/NOTES: _____