Fertility History
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A successful patient-practitioner relationship is possible when I have a complete understanding of your past and current health. Thank you for filling out this information to the best of your ability.

Name_____Date_____

Age at which menses began _____

Are you periods painful? Oyes Ono

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? Olight Onormal Oheavy

What color is the blood? Olight red Ored Odark red Opurple Obrown Oblack

Is there clotting? Oyes Ono

Do you have premenstrual tension? Oyes Ono

Does your face break out during your period? Oyes Ono

Do you have premenstrual breast tenderness? Oyes Ono

Do you bleed or spot between periods? Oyes Ono

Are your menstrual cycles spaced irregularly? Oyes Ono

How many days are there between one period and the next? _____

Date of last menstrual period?_____

How many pregnancies have you had? _____

How many children have you had? _____

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? Oyes Ono

Have you ever had a cervical biopsy operation, cauterization or conization? Oyes Ono

Have you ever had a sexually transmitted infection? Oyes Ono

Do you get yeast infections regularly? Oyes Ono

Have you ever been diagnosed with a chlamydial infection? Oyes Ono

Do you have chronic vaginal discharge? O yes O no

Have you ever had pelvic inflammatory disease? O yes O no

Were you treated for it? O yes O no

How?

Date of last pap smear?

Have you ever been diagnosed with endometriosis? O yes O no

Have you ever been diagnosed with fibroids or polyps? O yes O no

Have you been diagnosed with pelvic abnormalities? O yes O no

Have you taken any medications for gynecological conditions other than contraceptives? O yes O no

Medication	Reason	How Long

Have your cycles changed since they began? O yes O no

How?

Do you ovulate on your own? O yes O no

On what day of your cycle? _____

Are you currently charting your cycle and/or using ovulation predictor kits? O yes O no

Do your breasts get tender at/during ovulation? O yes O no

Do you get premenstrual low back pain? O yes O no

Do your bowels become loose at the beginning of your period? O yes O no

Have you had fertility treatments? O yes O no

If yes, when and where?

By whom?

What types?

Have you taken any medication to help you ovulate? O yes O no

When?

How long?

Have your fallopian tubes been evaluated medically? O yes O no

What were the results?

Have you had tubal operations? O yes O no

Have you had hormone laboratory tests performed? O yes O no

What were the results?

Do you have a single partner with whom you are trying to conceive? O yes O no

How long have you been married or living together? _____

If applicable, has your partner had a sperm analysis? O yes O no

What were the results?_____

Is your partner supportive in your wish to conceive? O yes O no

Have you taken oral contraceptives? O yes O no

When? How long? _____

Have you ever had an IUD? O yes O no

When? How long? _____

Have you ever taken DepoProvera? O yes O no

When? How long? _____

How long have you been trying to conceive?

Have you had a diagnosis related to infertility? O yes O no

What was it?

How is your sexual energy? O low O med. O high

Do you experience stress during sexual intercourse? O yes O no

Anything else you want to share about sexual intercourse? O yes O no

Do you douche regularly? O yes O no

With what?

Do you use vaginal lubricants? O yes O no

Are you more than 20% over your ideal body weight? O yes O no

Are you more than 20% below your ideal body weight? O yes O no

Do you have any history of an eating disorder? O yes O no

What was it? When?

Do you have a stressful occupation? O yes O no

Are you passionate about your daily work? O yes O no

Do you exercise regularly? O yes O no

Do you have excessive facial hair? O yes O no

Do you have excessively oily skin? O yes O no

Have you experienced excessive loss of head hair? O yes O no

Have you noticed discharge from your nipples? O yes O no

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? O yes O no

Have you been exposed to any known environmental toxins or hormones? O yes O no

Are you presently taking steroids? O yes O no

May I contact you to see how you are doing in 6 months? ○yes ○no

Is there anything else you would like to share with me? For example, are there any other health issues or concerns?