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## **WOMEN'S FERTILITY HISTORY**

NAME (First, Last, Middle)	DATE:	
Age at which Menses began  Are your periods painful?YesNo  How many days does the pain last?	Have you ever had Pelvic Inflammatory Disease?YesNo Were you ever treated for it?YesNo  How	
How many days do you normally bleed?  How heavy is the bleeding?LightNormalHeavy  What color is the blood?Light redRedDark redPurpleBrownBlack  Is there clotting?YesNo  Do you have premenstrual tension?YesNo  Does your face break out before or during your period?YesNo  Do your breasts become tender premenstrually?YesNo	Date of last Pap smear  Have you ever been diagnosed with uterine fibroids or polyps?YesNo  Have you ever been diagnosed with endometriosis?YesNo  Have you been diagnosed with pelvic adhesions?YesNo  Have you been diagnosed with any pelvic abnormalities?YesNo  Have you taken any medications for gynecological conditions other than	
Do you bleed or spot between periods?YesNo  Are your menstrual cycles spaced irregularly?YesNo  How many days are there from one period to the next?  Date of last menstrual period:	Medication Reason How Lo	ong 
Number Years  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?YesNo  Have you ever had a cervical biopsy, operation, cauterization or conization?	Have your cycles changed since they began? Yes No	
Have you ever had a cervical biopsy, operation, cauterization or conization? YesNo  Have you ever had a STD?YesNo  Do you have yeast infections regularly?YesNo  Have you ever been diagnosed with a chlamydial infection?YesNo  Do you have chronic vaginal discharge?YesNo  Do you have any sores on your genitalia?YesNo	Have your cycles changed since they began?YesNo  How?  Do you ovulate on your own?YesNo  On what day of your cycle?  Do you breast get tender at/during ovulation?YesNo  Do you get premenstrual low back pain?YesNo  Do your bowel movements become loose at the beginning of your period YesNo	

## WOMEN'S FERTILITY HISTORY Continued

Have you had fertility treatments?YesNo	How is your sexual energy?LowNormalHigh
If yes, when and where?	Do you douche regularly?YesNo
By Whom?	With what?
What types?	Do you use vaginal lubricants?YesNo
Have you taken medication to help you ovulate?YesNo	Are you more than 20% over your ideal body weight?YesNo
When How long?	Are you more than 20% under your ideal body weight?YesNo
Have you fallopian tubes been evaluated medically?YesNo	Do you exercise regularly?YesNo
What were the results?	Do you have excessively oily skin?YesNo
Have you had any tubal operations?YesNo	Have you experienced excessive loss of head hair?YesNo
Have you had any hormone laboratory tests performed?YesNo	Have you noticed discharge from your nipples?YesNo
What were the results?	Was your mother exposed to diethylstilbestrol (DES) when she was pregnar with you?YesNo
	Have you been exposed to any
Do you have a single partner with whom you have been trying to conceive?YosNo	known environmental toxins or hormones?YesNo
How long have you been married or living together?	Are you presently taking steroids?YesNo
Has he had a fertility workup?YesNo	
What were the results?	
Is your partner supportive of your wish to conceive?YesNo	
Have you taken oral contraceptives?YesNo	
When How Long?	
Have you ever had an IUD?YesNo	
When How Long	
Have you ever taken DepoProvera?YesNo	
When How Long	
How long have you been trying to conceive?	
Have you had a diagnosis relating to fertility?YesNo	
What is it?	
OMMENTS/NOTES:	