WOMEN'S FERTILITY HISTORY QUESTIONNAIRE

NAME: ____ DOB: _________________

Are your periods painful? Y N
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 BROWN BLACK PINK
Is there clotting? Y N

Do you have premenstrual tension? Y N
Does your face break out before your period? Y N
Do your breasts become tender premenstrually? Y N
Do you bleed or spot between periods? Y N
Are your menstrual cycles spaced irregularly? Y N
How man days from one period to the next? _______________
Date of last menstrual period ______________

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 have you had a D&C performed? ______________
Have you ever had an abnormal pap smear? Y N
    Date of last pap smear? ______________
Have you had a cervical biopsy, operation, cauterization or conization? Y N

Have you ever had a sexually transmitted disease? Y N
Do you get yeast infections regularly? Y N
Have you ever had pelvic inflammatory disease? Y N
    Were you treated for it? Y N
Have you ever been diagnosed with uterine fibroids or polyps? Y N
Have you eve been diagnosed with endometriosis? Y N
Have you ever been diagnosed with pelvic adhesions? Y N
Have you ever been diagnosed with pelvic abnormalities? Y N

Have you taken any medications for gynecologic conditions other than contraception?
Y N
    Which medications? ____
    ____

Do you ovulate on your own? Y N On what day of your cycle? ______________
Do your breasts get tender at/during ovulation? Y N
Do you get premenstrual low back pain? Y N
Do your bowel movements become loose at the beginning of your cycle? Y N

WOMEN'S FERTILITY HISTORY QUESTIONNAIRE

Have you had any fertility treatments? Y N

If yes, please indicate the treatment and approximate date:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Have you ever taken medication to help you ovulate? Y N

How many cycles? __________

Have your fallopian tubes been medically evaluated? Y N

What were the results? ______________________________

Have you had any tubal operations? Y N

Have you had any hormonal laboratory tests performed? Y N

What were the results? ______________________________

____

____

Do you have a single partner with whom you are trying to conceive? Y N

How long have you been trying to conceive? ______________________________

Has your partner has a fertility evaluation? Y N

What were the results? ______________________________

Have you taken oral contraceptives? Y N

If so, for how long? ____________________

Have you ever had an IUD? Y N

If so, for how long? ____________________

Have you ever taken Depo-Provera? Y N

If so, when and for how long? ______________________________

Do you have a diagnosis relating to infertility? Y N

What is it? ______________________________

How is your sexual energy? LOW NORMAL HIGH

Do you use vagina lubricants? Y N Which one? ____________________

Do you have a stressful occupation? Y N

Do you experience a lot of emotional or mental stress? Y N

Do you exercise regularly? Y N

What kind of exercise? ______________________________

Do you have excessive facial or body hair? Y N

Do you have oily skin? Y N

Have you experienced head hair loss? Y N

Have you been exposed to any known environmental toxins or hormones? Y N
Are you currently taking any steroids? Y N

Current medications NOT related to fertility treatment:

1. ____
2. ____
3. ____

Additional health conditions not related to fertility:

1.
2.
3.
4.
5.